Health and Social Care Scrutiny Sub-Committee AGENDA

DATE: **Thursday 4 September 2014**

TIME: **7.30 pm**

VENUE: **Committee Rooms 1 & 2, Harrow Civic Centre**

MEMBERSHIP **(Quorum 3)**

Chairman: **Councillor Mrs Rekha Shah**

Councillors:

Michael Borio (VC)
Niraj Dattani
Mrs Vina Mithani
Chris Mote

Reserve Members:

1. Kairul Kareema Marikar
2. Jo Dooley
3. Sasi Suresh

1. Lynda Seymour
2. Jean Lammiman

Advisers:

To Be Appointed

Contact: **Manize Talukdar, Democratic & Electoral Services Officer**
Tel: 020 8424 1323 E-mail: manize.talukdar@harrow.gov.uk

Harrow COUNCIL LONDON

AGENDA - PART I

1. ATTENDANCE BY RESERVE MEMBERS

To note the attendance at this meeting of any duly appointed Reserve Members.

Reserve Members may attend meetings:-

(i) to take the place of an ordinary Member for whom they are a reserve;
(ii) where the ordinary Member will be absent for the whole of the meeting; and
(iii) the meeting notes at the start of the meeting at the item 'Reserves' that the Reserve Member is or will be attending as a reserve;
(iv) if a Reserve Member whose intention to attend has been noted arrives after the commencement of the meeting, then that Reserve Member can only act as a Member from the start of the next item of business on the agenda after his/her arrival.

2. DECLARATIONS OF INTEREST

To receive declarations of disclosable pecuniary or non pecuniary interests, arising from business to be transacted at this meeting, from:

(a) all Members of the Sub-Committee;
(b) all other Members present.

3. MINUTES (Pages 1 - 6)

That the minutes of the meeting held on 7 July 2014 be taken as read and signed as a correct record.

4. PUBLIC QUESTIONS *

To receive any public questions received in accordance with Committee Procedure Rule 17 (Part 4B of the Constitution).

Questions will be asked in the order notice of them was received and there be a time limit of 15 minutes.

[The deadline for receipt of public questions is 3.00 pm, 1 September 2014. Questions should be sent to publicquestions@harrow.gov.uk

No person may submit more than one question].

5. PETITIONS

To receive petitions (if any) submitted by members of the public/Councillors under the provisions of Committee Procedure Rule 15 (Part 4B of the Constitution).

6. REFERENCES FROM COUNCIL AND OTHER COMMITTEES/PANELS

To receive any references from Council and/or other Committees or Panels.

7. APPOINTMENT OF (NON-VOTING) ADVISERS TO THE SUB-COMMITTEE 2014/15 (Pages 7 - 10)

Report of the Director of Legal and Governance Services.

8. PUBLIC HEALTH INTEGRATION (Pages 11 - 28)

Report of the Director of Public Health.

9. CARE QUALITY COMMISSION'S QUALITY REPORT ON THE NORTH WEST LONDON HOSPITALS NHS TRUST (Pages 29 - 206)

Report of the Care Quality Commission.

10. ANY OTHER BUSINESS

Which the Chairman has decided is urgent and cannot otherwise be dealt with.

AGENDA - PART II - NIL

*** DATA PROTECTION ACT NOTICE**

The Council will audio record item 4 (Public Questions) and will place the audio recording on the Council's website, which will be accessible to all.

[**Note:** The questions and answers will not be reproduced in the minutes.]

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HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE

MINUTES

7 JULY 2014

Chairman:	*	Councillor Mrs Rekha Shah		
Councillors:	*	Michael Borio	*	Mrs Vina Mithani
	*	Kairul Kareema Marikar (1)	*	Chris Mote
Advisers:		Rhona Denness	-	Harrow Healthwatch

* Denotes Member present
(1) Denotes category of Reserve Member

1. Attendance by Reserve Members

RESOLVED: To note the attendance at this meeting of the following duly appointed Reserve Members:-

Ordinary Member	Reserve Member
Councillor Niraj Dattani	Councillor Kairul Kareema Marikar

2. Appointment of Vice-Chairman

RESOLVED: That Councillor Michael Borio be appointed Vice-Chairman for the 2014/15 Municipal Year.

3. Declarations of Interest

RESOLVED: To note that the following interests were declared:

All Agenda Items

Councillor Michael Borio declared a non-pecuniary interest in that he was employed by Independent Age. He would remain in the room whilst the matters were considered and voted upon.

Councillor Kairul Kareema Marikar declared a non-pecuniary interest in that she was employed by a foster caring organisation. She would remain in the room whilst the matters were considered and voted upon.

Councillor Mrs Vina Mithani declared a non-pecuniary interest in that she was employed by Public Health England. She would remain in the room whilst the matters were considered and voted upon.

Councillor Chris Mote declared a non-pecuniary interest in that his daughter was employed by Northwick Park Hospital. He would remain in the room whilst the matters were considered and voted upon.

4. Minutes

RESOLVED: That the minutes of the meeting held on 23 April 2014, be taken as read and signed as a correct record.

5. Public Questions and Petitions

RESOLVED: To note that no public questions or petitions were received at this meeting.

6. References from Council and Other Committees/Panels

The Sub-Committee received the following Reference from the Cabinet: Response to NHS Health Checks Scrutiny Review.

RESOLVED: That the Reference from Cabinet be noted.

RESOLVED ITEMS

7. Harrow Local Safeguarding Adults Board (LSAB) Annual Report 2013/2014

The Sub-Committee received a report of the Director of Adult Social Services which set out an overview of the Local Safeguarding Adults Board (LSAB) annual report for 2013/14.

Following a brief officer presentation highlighting key aspects of the report, Members made the following comments and asked the following questions:

- How often were audits carried out, what selection process was there for external auditors and how were issues of non-compliance dealt with?

An officer advised that the data from internal monthly audits was collated on a quarterly basis to inform practice learning. External audits of cases selected at random, were carried out on a quarterly basis by independent social workers who were selected for their specialist skills and knowledge.

The safeguarding of adults national agenda is improving fast and there had been a lot of development in this area of work in the last decade. Guidance from best practice forums helped to target specific issues and outcomes from these helped to inform the staff training strategy. For example, training on the Mental Health Capacity Act had been offered in 2013.

- Were there any resource implications as a result of the recent Supreme Court ruling relating to the threshold for DOLS (Deprivation of Liberty Safeguards)?

  The officer advised that this was a statutory requirement which had timescales attached. In 2013, fourteen referrals had been made, and the figure to date for 2014 was fifty four. Each referral cost in the region of £350.00. As a result of Supreme Court ruling DOLS threshold have changed. Therefore significant increase in referrals put pressures on the service. Officer also informed that there has been no breach in timescales in Harrow.

- How did safeguarding adults differ from safeguarding children?

  The officer stated that safeguarding children was covered by the Children's' Act and that currently there was no specific legislation dealing with Adults. The Care Act, due to be enacted in 2015, would give statutory status to the LSABs, additional powers and responsibilities to local authorities and would require partner representation on LSABs.

- Why had the number of referrals for patients from BME communities decreased since 2013? Why were the number of mental health referrals lower than other types of referrals?

  The officer advised that the number of referrals for people from BME communities had increased but the percentage of referrals had decreased. It may have been due to an increase in the number of referrals from older people and they are mostly represented by white British people. The data was still being analysed the data. However, the service would continue to target faith and community groups to improve awareness and engagement.

  With regards to mental health, the service was working closely with CNWL (Central & North West London NHS Foundation Trust) in the area of mental health to increase the number of referrals from Mental Health services.

The Director of Adult Social Services stated that increased numbers of referrals were a good indication of increased awareness among the public regarding safeguarding adults' issues. It was important that referrals to the relevant teams, whether it be social work, reablement, safeguarding etc, were dealt with in a timely and appropriate manner.

- In view of the fact that Children Looked After (CLAs) by the authority, continued to be the responsibility of the authority beyond the age of 18 years of age, what was being done about ensuring they did not fall through the net?

  The officer advised that Adult services had a dedicated transition team which worked closely with Children's Services to ensure no one fell through the net. In addition, Adult Services and Children's Services had produced a protocol to ensure that these young adults did not fall through the net.

- How were individuals making allegations dealt with?

  The officer advised that this appropriate staff training was key in ensuring that those making referrals were dealt with sensitively. Safeguarding decision-making was a complex process and was carried out at strategy meetings and on occasion, the history and the capacity of the person making the referral was taken into consideration.

- What was the reason for the high level of allegations of abuse against social care staff and family members in Harrow?

  The officer advised the fact that a very large proportion of service users in Harrow were not in residential care but were supported at home by family members or carers and therefore the proportion of allegations against them was likely to be higher.

- What workforce development and staff training strategies were in place?

  The officer advised that the staff training strategy was co-produced with users and partner organisations. There was a mandatory element to the training and this information was published online. User feedback was used to inform staff training and development.

RESOLVED: That the report be noted.

8. Healthwatch Harrow - Progress

The Sub-Committee received a report of the Divisional Director of Strategic Commissioning which set out the progress made in establishing a local Healthwatch in Harrow, its current performance and future work plans.

Following a brief overview of the report by the representative from Healthwatch Harrow, Members asked the following questions and made the following comments:

- How would the action plan be delivered?

  The representative from Healthwatch Harrow advised that there was a framework in place which the action plan was based on. He anticipated that different methodologies would emerge in forthcoming months. Patient-engagement, through surveys and GP surgery networks etc would be a key driver for success. Targets had been set for publicity and awareness raising and the organisation was looking at ways of engaging the business and private sectors.

- What assessment of its performance during its first year had been carried out?

  The Healthwatch Harrow representative stated that discussions with the local authority regarding the performance monitoring framework had taken place. Some areas of performance required improvement, however, priorities had been set and performance was measured against the Local Government Association's guidelines.

- What was the selection process and how were the key performance indicators (KPIs) decided and measured?

  The Healthwatch Harrow representative stated that this had been set at 20% for the first year. Performance would be measured through focus groups. Lay members would be appointed.

- How were complaints dealt with?

  The Healthwatch Harrow representative stated that few complaints had been received to date and that these generally related to issues with A&E services and GP surgery waiting times. All complaints received were logged and followed up. There was a signposting service to the advocacy service and feedback was provided through the local Patient Participation Network.

- What was being done to engage with those groups considered to be 'hard to reach'?

  The representative from Healthwatch stated that it would be important to build links and trust with the community and identifiying these groups and engaging with them may prove to be a resource-intensive exercise.

  The Divisional Director of Strategic Commissioning stated that Harrow in Business, which was a consortium made up of local third sector groups with strong links to their communities would work closely with Healthwatch to reach these groups.

RESOLVED: That the report be noted.

9. Royal National Orthopaedic Hospital: Quality Accounts 2013/14

The Sub-Committee considered a report of Assistant Director of External Compliance and Quality at the Royal National Orthopaedic Hospital which set out RNOH's Quality Accounts for 2013/14. The Assistant Director was not present at the meeting to respond to Members questions and it was noted that this item had been deferred from the previous meeting.

RESOLVED: That

(1) the report be noted;

(2) Members email any questions they had regarding the report to the Assistant Director of External Compliance and Quality at the Royal National Orthopaedic Hospital.

(Note: The meeting, having commenced at 7.30 pm, closed at 8.45 pm).

(Signed) COUNCILLOR MRS REKHA SHAH
Chairman

REPORT FOR: **HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE**

Date of Meeting:	4 September 2014
Subject:	Appointment of (non-voting) Advisers to the Sub-Committee 2014/15
Responsible Officer:	Hugh Peart, Director of Legal and Governance Services
Exempt:	No
Enclosures:	None

Section 1 – Summary and Recommendations

This report advises Members on the appointment of two non-voting advisers to the Sub-Committee. Members are requested to consider and agree the appointment of the advisers to the Sub-Committee for the 2014/15 Municipal Year.

Recommendations:
That, in accordance with the Committee Procedure Rules (Part 4B of the Constitution - Rule 33.9),the nominees named in this report, be appointed as advisors to the Sub-Committee for the 2014/15 municipal year.

Reason:
To appoint non-voting advisers for the 2014/15 Municipal Year, to assist in the work of the Sub-Committee.

Section 2 – Report

Background

2.1 Rule 33.9 of Committee Procedure Rules provides for a Scrutiny Sub-Committee to appoint non-voting advisers (to assist in the work of the Sub-Committee either generally or on specific matters). Advisers are subject to the Protocol on Co-optees and Advisers, Part 5H of the Constitution.

2.2 At its meeting on 7 December 2010, the Health Scrutiny Sub-Committee requested that Harrow LINk and the Harrow Local Medical Committee (LMC) be requested to each nominate up to two of their members to become non-voting advisers to the Sub-Committee for the 2011/12 Municipal Year.

2.3 Harrow LINk has now been replaced by HealthWatch Harrow. The following individual from HealthWatch Harrow, who served as an adviser in 2013/14, has confirmed that she wishes to continue to act as an adviser to the Sub-Committee for the 2014/15 Municipal year: Rhona Denness.

2.4 In addition, the LMC have nominated the following individual to replace Dr Nicholas Robinson, who retired in 2013: Dr Nizar Merali.

2.5 If appointed, the advisers will be required to comply with the Council's Protocol on Co-optees and Advisers.

Financial Implications

2.6 None.

Risk Management Implications

2.7 If not appointed, the Sub-Committee may not have access to expert external advice when conducting its business.

Equalities implications

2.8 Supports the Council's Public Sector Equality Duty.

Corporate Priorities

2.9 Promotes 'Making a difference for Communities', by enabling representation on a Scrutiny Committee from the voluntary and community sector in Harrow.

Section 3 - Statutory Officer Clearance

Name: Steve Tingle Date: 5.8.14	x	on behalf of the Chief Financial Officer
Name: Paresh Mehta Date: 8.8.14	x	on behalf of the Monitoring Officer

Section 4 - Contact Details and Background Papers

Contact: Manize Talukdar, Democratic and Electoral Services Officer 020 8424 1323

Background Papers: None

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REPORT FOR:	**Health & Social Care Scrutiny Sub-Committee**
Date of Meeting:	4 September 2014
Subject:	Public Health integration
Responsible Officer:	Andrew Howe, Director of Public Health
Scrutiny Lead Member area:	Councillor Michael Borio, Policy Lead Member & Councillor Mrs Vina Mithani, Performance Lead Member
Exempt:	No
Wards affected:	All
Enclosures:	**Appendix 1 –** Service Achievements in 2013-14 **Appendix 2** – Working with Councils

Section 1 – Summary and Recommendations

This report sets out the work and experience of the Joint Public Health Service in its first year of operation 1 April 2013 to 31 March 2014.

Recommendations: The Sub-Committee is requested to note the report

Section 2 – Report

Introduction

The Joint Public Health Service was established on 1st April 2013 on transition from the National Health Service. The Service is hosted by Harrow Council and provides a joint service to Barnet Council.

The report sets out the work of the Joint Public Health Service in its first year of operation - 1st April 2013 to 31st March 2014.

Context

The Joint Public Health Service works for Barnet and Harrow Councils. Both boroughs have similar health profiles and needs and deliver similar services in responding to these needs. The team works with both councils and organisations within the NHS – Clinical Commissioning Groups, NHS England and Public Health England. The Public Health Service has formal links to all of these organisations in order to fulfil statutory requirements and to ensure effective health provision for both boroughs.

Responsibilities and Functions

The Joint Public Health Service has four key responsibilities:
1. Leading health Improvement and reducing health inequalities
2. Health protection and ensuring appropriate plans are in place.
3. Public health support to health service commissioning and joint commissioning
4. Providing public health knowledge and intelligence

The Division is made up of the following functions:

- **Director of Public Health role**
    - Surveillance & assessment of populations' health and wellbeing
    - Assess the evidence of effectiveness of health and social care interventions, programmes and services
    - Policy and strategy development and implementation

- Leadership and collaborative working for health

- **Procurement & commissioning of health improvement services**

  - Review current services and pathways of care
  - Review/ develop service specifications based on evidence of effectiveness and cost effectiveness
  - Procurement and contract negotiation
  - Contract monitoring and performance assessment
  - Commission & performance managing health improvement programmes
  - Supporting commissioning activity within CCGs, the NHS England and PHE
  - Supporting commissioning activity within the Councils

- **Health improvement**

  - Interpretation and application of new policies
  - Coordinate health improvement projects and programmes and monitor and evaluate them
  - Involve the public in assessing their health and wellbeing needs and identify means to address such needs

- **Public Health analysis**

  - Collection & analysis of data on defined populations
  - Support identification & evaluation of user strategic need for health data and intelligence and negotiation of solutions
  - Disseminate health data and intelligence from diverse sources to various audiences
  - Inform and influence policy and priority setting and performance
  - Assess relevance and usability of health data and intelligence, methods and systems

<u>Overview of Year</u>

The year 2013-14 was the first year for the joint Public Health Service. The year has been one of transition from the NHS and embedding functions within councils and developing a wide range of relationships within Councils.

Key highlights are given here with more information attached at Appendix 1.

The Service has been developing and refining the way it works with two Councils and the new organisations within the NHS – Clinical commissioning Groups, NHS England and Public Health England; and how resources are

deployed to best effect to support the local populations. This will continue to be an on-going focus for the Service.

New investment totalling £1.65 million across the two councils has been deployed across a range of new services and initiatives. This has proved a significant challenge for the service while at the same time delivering all of it's statutory and previously existing discretionary services.

Much work has gone into reviewing contracts and negotiating with providers which again has required significant time and resources. The overall quality and cost of services has been maintained similar to that of the last year in the Primary Care Trust. Significant savings have been made on GUM contracts with the Service leading on some of the negotiations for the West London Alliance.

The findings of a review of school nursing and health visiting are being used to inform service development. Useful links were established while undertaking the review with local and national partners and providers which paved the way for developing detailed proposals for the children's integrated health offer. This is an important piece of work as it includes preparation for the receipt of Health Visiting services in 2015.

The Service has also established an extensive range of working links within the Councils and local partners. The scale and breadth of this work is given at Appendix 2.

Finance

The Service is funded by a ring fence grant from Central Government. The ring fence continues in 2014-15. The budgets for 2013 -14 were:

Harrow: £8,874,000
Barnet: £13,799,000

Performance

Performance summary

Harrow PH scorecard indicators

Three high level indicators were chosen in Harrow to reflect the long term health status of the population.

Premature mortality from cancer is the lowest in England and is continuing to fall. Premature mortality from circulatory diseases also continues to fall and is in the lowest 5% of English Local Authorities.

Smoking is a major risk factor for both premature mortality indicators and so smoking prevalence (percentage of adults who smoker) was chosen as the third high level indicator. It gives an indication of longer term health trends. The rate of smoking in Harrow has continued to decrease from 14.6% in 2012

to 13.2% at the end of 2013. This continues to be considerably lower than the national rate.

Getting a good start in life is vital and we chose breast feeding rates as an indicator for this. NHS England are now responsible for collecting and collating the data on this indicator. There have been some problems across the country in accessing accurate data but the majority of these now seem to be resolved, However, data for harrow, Brent and Ealing is not held on the CHIS and must be collected from GPs. This means that the data does not meet all of the validation criteria required by the Department of Health The data for Harrow shows that 68.1% of babies were either fully or partially breast fed at 6-8 weeks in 2013-14 but that the status is unknown for 22% of babies. This gap in availability of data has made it difficult to assess the impact of the work being undertaken in hospitals, GP surgeries, children's centres and by community midwives, health visitors and the peer support programme, established and funded by the Harrow Public Health team.

Drugs and Alcohol programmes not only improve the lives of the people who use them but also has an impact on their families and on the wider community in terms of community safety and reducing crime rates. The indicators chosen looks at the medium term impact of the drug and alcohol services rather than just the short term impact. We measure the number of people successfully treated who did not come back into any drug and alcohol service in the country in the following 6 months. The data shows that the local services are successful in sustaining longer term behaviour change with over 12% of opiate users and over 46% of non-opiate users not returning to services compared to 8.4% and 40.2% nationally.

Not all of the indicators have shown good performance. The transfer of services to the council and the problems with the payments to the stop smoking service providers which resulted in no payments for their work until quarter 3, meant that they were reluctant to promote and deliver the services. As a result, the smoking quitter target was not met in 2013-14. Targets for 2014-15 have been reassessed to coincide with the significant drop in smoking prevalence (from 14.6% to 13.2%).

The Health Checks programme was similarly affected by transition. The service is currently delivered solely by general practices. The changes to the health systems in April 2013 have had repercussions in practices with many practices prioritising the projects and initiatives promoted by the CCG rather than delivering the challenging health checks targets. Combined with payment issues, the practices did not deliver on their health checks targets. The service increased performance in the last quarter. The changes that are planned include an improved data collection method which will mean that the practices will not have to do additional work to report their performance; ad hoc community events which will take place throughout the summer; and additional providers will be commissioned to both provide an alternative to the practice as a venue to get a health check and to increase the reach of the programme by providing a service to people in practices that have not signed up to the programme. This new service should be in place by the autumn. The national estimate of the population needing a health check has also been revised and in line with this we have readjusted the targets for 2014-15.

2014-15 PH Scorecard

We have expanded the number and range of indicators we will report on in 2014-15. We have excluded the high level indicators as they are covered in the PHOF which we report on separately. The indicators represent the broad range of responsibilities of the public health team. Some of these will be challenging and some are not solely within the remit of the public health team to deliver. The indicators are:

- Number of people setting a quit date with SC services who successfully quit at 4 weeks
- Increased number of drug users successfully completing drug treatment and not returning within 6 months - opiate users
- Increased number of drug users successfully completing drug treatment and not returning within 6 months - non-opiate users
- Number of people receiving brief advice about alcohol (ABI)
- Number of medium/large employers signing up to the healthy workplace charter
- % of people with needs relating to STIs who have a record of a) being offered and b) % accepting an HIV test at first attendance (excluding those already diagnosed HIV positive).
- Number of eligible people receiving health checks
- Reduction in numbers of mothers that smoke at time of delivery
- Proportion of children aged 4-5 classified as overweight or obese
- Proportion of children aged 10-11 classified as overweight or obese
- Number of schools registered for the Healthy Schools London Awards - a) primary b) secondary
- Numbers of schools and children's centre taking part in the oral health promotion campaign

The National Public Health Outcomes Framework

The Public Health Outcomes Framework is part of Healthy lives, healthy people: Improving outcomes and supporting transparency. It sets out a vision for public health with desired outcomes and a set of indicators that will help us understand how well public health is being improved and protected.
The framework concentrates on two high-level outcomes to be achieved across the public health system; life expectancy and the inequality gap (as measured by the slope index of inequality). The framework groups further indicators into four 'domains' that cover the full spectrum of public health, from housing to health services; from fruit and vegetable consumption to fuel poverty; from violence to vaccinations and from education to emergency admissions.

- Domain 1: Improving wider determinants
- Domain 2: Health improvement
- Domain 3: Health Protection
- Domain 4: Healthcare public health and preventing premature mortality

The outcomes reflect a focus not only on how long people live, but on how well they live at all stages of life.

The outcomes indicators will be discussed as part of updating the Health and Wellbeing Board Strategy.

Risk

For risk, the past year has been largely focused on managing the transition and the risks that arise as a result of this. The introduction of the Health and Social Care Act 2012 resulted in one of the largest single transformations that the NHS had witnessed for a decades. Inevitably with the abolition or organisations and transfer of functions to numerous entities, risks will undoubtedly arise.

There was acknowledgement across the Health and Social Care system that whilst legislation required organisations to take on their new responsibilities from the 1st April 2013, systems and structures would not be fully implemented and operational by that date. There is a level of interdependency between Public Health and a number of organisations; particularly Public Health England. Whilst we were waiting for systems and processes to be embedded, we managed this risk through increased monitoring and liaison with partners.

Whilst significant effort was invested in readiness for the transition; the novation of individual service contracts was considered to be of high risk. Effective management of the contracts by Commissioners ensured that negotiations were concluded efficiently and within the financial envelope proposed within the Commissioning Intentions.

The management of clinical risk within service contracts and the resulting framework in which this operates is, to some extent, new to Local Authorities. Whilst we are developing a common Clinical Governance framework across the Barnet and Harrow shared service, we have implemented additional systems to monitor clinical related risks with our providers that affect the service delivery of our contracts.

Public Health continues to report regularly, via individual Performance Boards and the joint Governance Board on risks encountered within the service. This effective reporting has enabled continuous oversight by the each Authority; providing assurance that risk is managed effectively.

Corporate Priorities

Please identify how the report incorporates the administration's Corporate Priorities Listed below:

The Council's vision is Harrow:

- Making a difference for the vulnerable
- Making a difference for communities
- Making a difference for all businesses
- Making a difference for families
- An Efficient and Effective Organisation

The Public Health Service in Harrow contributes to corporate priorities in the following areas:

Corporate Priority	Public Health contribution
Making a difference for the vulnerable	Older people - Contributing investment to delay onset of ill health, supporting expansion of self-care, maintaining mobility and tackling social isolation. Diabetes self care. Expert patient programme. Winter Warmth. Employment - public health work includes development of targeted services to help people into work with the lead for addressing health related barriers to entering employment e.g. drug and alcohol dependence. Working with GPs to identify people on long-term sickness benefit, who could be supported back into work Commissioning health counselling for long-term unemployed Mental Health promotional work
Making a difference for communities	Promoting physical activity outside via environmental improvements and behavioural interventions building on existing investments, e.g. Green Gyms. The Public Health Service recruits and supports volunteer lead walks programmes which are open to all borough residents. The provision of services (e.g. health checks, smoking cessation, promoting physical activity) the Service also works with local and national NHS
Making a difference for local businesses	Supporting business to understand DDA compliance Working in partnership with Economic Development Continuing support for implementation of the London Healthy Workplace Charter in Harrow.

Making a difference for families	Public Health is working closely with its commissioned drug and alcohol service providers and partners to ensure that service users are able to reduce and end their dependencies. (Indicator: The percentage of individuals leaving treatment drug-free and not returning to treatment within 6 months) Contributions to educational achievement from better emotional wellbeing – schools programme. Input to early help in Children's Centres. Early years - Development of single children's health offer (with transition of health visiting from the NHS to local authorities in 2015): investing in pre- and post- natal support and develop parenting skills programmes and tackling obesity in early years
An Efficient and Effective Organisation	As a shared service with The London Borough of Barnet, Public Health is maximising efficiencies through the development of joint strategies and service re-procurements.

Section 4 - Contact Details and Background Papers

Contact: Dr. Andrew Howe, Director of Public Health
Tel: 020 8420 9501 Email: andrew.howe@harrow.gov.uk

Appendix 1 Service Achievements in 2013-14

Harrow

- The Alcohol Identification and Brief Advice (IBA) in Community Pharmacy service started and commissioned 15 pharmacies across Harrow. All pharmacies signed up have at least one pharmacist trained in IBA and began in November 2013 to deliver the service to users of the pharmacies and residents who wanted support around safer drinking. The service was for Alcohol Awareness Week and publicity included a stall in the town centre, posters and pop up banners around Harrow to let people know about the new service which offers assessment of drinking and advice on how to manage alcohol in safe way.

- The improving access to fruit and vegetables among families project was initiated. This project is training parents to run fruit and vegetable stalls in schools and a provider has been allocated to train parents, offer healthy eating support and to ensure the stalls are managed to become self sufficient. Schools have recruited parents to run the stalls and the project will ensure that parents receive training that improves confidence, skills and employability. The stalls have also started January 2014 and schools are using the stalls as a platform to engage on healthy eating with their parents and pupils.

- Outdoor Gym Project has been successful in helping Harrow resident's access outdoor gym equipment in local parks. Volunteers trained as Level 2 Fitness Instructors provided support and guidance to outdoor gym users. A small scale survey which was carried out between June and November 2013 indicated improved access and satisfaction by users.

- Public Health has been coordinating a review of the obesity pathway for adults and children in Harrow with a group of stakeholders. An obesity needs assessment is now in draft form and key stakeholders and the community will be part of a wider consultation in January 2014. The Harrow Obesity Strategy 2014 will be drafted in the next two months and taken to the Health and Wellbeing Board in March 2014

- The Learning Disability Needs Assessment was completed and used by Harrow CCG and Social Care for the Joint Health and Social Care Learning Disability Self-Assessment Framework.

- A clear evaluation framework for the tool supporting long term conditions at the primary care level was developed as a part of joint NWL Integrated Care Pilot

- The Public Health Team led on implementation of the London Healthy Workplace Charter in Harrow. The project is based on the Greater London Authority initiative to recognise and support

business investment in staff health and wellbeing. Our local project also encompasses support for the Healthy Catering Initiative launched by Harrow Environmental Health Team in 2012. Partnership working with Harrow in Business and the Healthwatch Harrow has helped to develop a strategy to engage with local employers. The Public Health Team is pleased to confirm Harrow Council's participation as an employer in the first phase of work towards the verification process for the London Workplace Charter, which will lead as an example to local employers.

- Adult services were introduced to the Harrow Health Improvement Schemes to improve access to healthy lifestyle services. Public Health contributed to the Integrated Care Pilot - a joint initiative between CCG and Adult services to reduce A&E attendance. As part of this Health Improvement services introduced to a group of patients with a high number of visits to A&E.

- Mental health promotion and wellbeing strategy has been drafted and consulted with key stakeholders. A wider public consultation was held in February 2014.

- Mental Health Promotion programme encompassing workplace mental health training for council staff, activity based training for staff working with older people in residential care homes and Outreach information and advice sessions for difficult to engage older people is being commissioned from external providers.

- Joint working with Silverstar Diabetes to arrange for their mobile testing unit to be at various locations around the borough to raise awareness about diabetes and offer a diabetes health check for people at higher risk of developing it.

- Co-ordinated public health involvement and presence at Harrow Under One Sky.

- Running Expert Patient programme for people living with long term conditions to help them to become better self managers. Also trained a new EPP tutor who has passed assessment.

- Walk programme continuing to run with walks across the borough and numbers of walkers increasing.

- Harrow Reablement Social Services Team introduced to Harrow Health Improvement services via meetings and presentations.

- The in house smoking cessation service achieved the National Centre for Smoking Cessation and Training (NCSCT) accreditation in November – the first service in the country to do so.

- Much useful work has been undertaken with the West London Alliance with the service leading on a number of contract areas

resulting in financial savings and efficiencies. A 17% increase in volume in Drug and Alcohol services with no decline in quality and savings of £117k on GUM contracts.

- Work was undertaken in children's centres to promote healthy eating including nutrition and cooking workshops for parents and children. The Public Health team are currently part of a working group developing standardised weaning guidance across Harrow.

- Work undertaken with Ealing Hospital NHS Trust (Integrated Care Organisation) to appoint an oral health coordinator to work on a part time basis across the borough delivering a tooth brushing programme in primary schools and nurseries and supporting the oral health workshops that already take place within children's centres. Health visitors have been trained in delivering the brushing for life programme and will distribute the brushing for life information packs at children's developmental reviews. Work also undertaken with the Public Health England Dental Public Health consultant to encourage local dentists to apply fluoride varnish and to promote fluoride varnish amongst parents.

- The Winter-well programme distributed 3,500 leaflets and information packs on the subject of 'winter warmth' to vulnerable adults and older people known to Adult Social Services, of these 428 were identified as highly vulnerable. This group was contacted directly by the Winter Well Team and offered a home visit to assess the need for draft proofing, further insulation and central heating boiler upgrade/ replacement. Packs including slippers and electric blankets were also delivered to this group.

- £350,000 of new investment was deployed to support work on childhood obesity, a review of the school nursing service in preparation for health visitors joining the Council in April 2015 (to ensure a joined up preventive health support for Children 0-19 is in place), warmer homes, work to improve the older peoples health and social care pathway (undertaken by Adults Services). Harrow Childhood obesity, Alcohol brief advice in pharmacies, and healthy eating in schools and Children's Centres.

Barnet

- Early Years Programme - Healthy Children's Centre Standards – which consist of a range of priority health areas including nutrition, physical activity, breastfeeding, and oral health - were implemented in January. A Service Level Agreement was agreed with Family Support and Early Intervention at Barnet Council to provide support to Children's Centres to implement these standards.

- Engagement work has been undertaken with Barnet Dentists and a Dental Health Consultant with Public Health England to link dental practices to children's centres.

- Barnet Schools Wellbeing Programme - The Programme is underway providing resources, training and consultancy support for physical activity, healthy eating, emotional wellbeing (EWB) and Tobacco Control. Procurement for separate providers to deliver the Sex and Relationships Education (SRE) and the Drugs & Alcohol work streams has commenced. The overall programme is currently focused on universal intervention and consideration is now being given to the potential efficacy of developing targeted programmes; for example, for childhood obesity.

- The provider, the Health Education Partnership (HEP) has provided consultancy support in 8 primary schools in the borough to date – of these four were to support renewal of Healthy School status, two for Healthy Eating and two for Personal, Social and Health Education (PSHE). HEP has also provided two Emotional Wellbeing and Nutrition training courses open to all primary schools in the borough in November. 23 primary schools have registered for Healthy Schools (London) with HEP to support the schools to meet the criteria for the Bronze Award initially.

- A meeting with Head teachers in the Borough was held on 14th November to discuss extending the Wellbeing Programme to Secondary Schools. The commissioning of providers to support secondary schools is underway.

- Sex and Relationships Education and Clinic in a Box have now been commissioned and will be available in January. Smoking prevention and Drugs & Alcohol awareness work streams are also expected to commence during January.

- Alcohol brief intervention initiative in Pharmacies commenced in early November in 21 pharmacies in Barnet. The service provides risk assessment and case Identification with brief structured advice for those at risk, provision of supportive literature and referral to specialist services where appropriate. To date (with some pharmacies still to submit data) 220 people have received an alcohol screen. 45% of these (98 people) were consuming at a higher risk level and received brief advice. 13 further people were referred to the alcohol treatment service.

- Outdoor gyms, marked & measured routes and the activator programme

- Consultation and procurement for the gyms is completed with installation by March 2014. The Activator programme will provide fitness instructor training opportunities for residents who will then provide advice and motivational support at the outdoor gyms from their formal launch in April. Middlesex University has been appointed to provide the training and delivery of the Activators.

- Physical activity opportunities for older people

The small grants scheme for community physical activity opportunities has been launched. Expansion of walking schemes, dance programmes and tai chi provision is anticipated. The scheme was launched on 12th November with invitations extended to a range of organisations across the Borough. A website has been developed to support this initiative
http://www.barnet.gov.uk/info/940439/physical_activity_grants_for_older_adults/1152/physical_activity_grants_for_older_adults

- 10 residential homes in the borough have received 13 exercise DVDs. Of their 400 residents overall, the target audience is 168. One home is adapting the DVD to make it appropriate for their residents. The others are using the DVD as produced.

- Fit and Active Barnet Campaign
  The Fit and Active Barnet campaign was launched in January 2014.It will run throughout 2014 and will involve a coordinated sequence of events and media stories.

- Supporting those affected by welfare reform back to work
  Health promotion advice and motivational support will be provided for those affected by welfare reform. A provider has been commissioned and the service commenced in January 2014.

- Supporting people into work who have a mental health or learning disability
  A programme of Individual Placement Support for patients with mental health diagnoses and learning disabilities was launched in early 2014.

- In a recent publication of the Municipal Journal, Barnet was placed 4th in a National table of Local Authorities for its work on tackling health inequalities and the wider determinants of health. These results are the early signs of the benefits that can be achieved of cross organisational working between Public Health and our colleagues within other directorates.

- Work with the West London Alliance with the service leading on a number of contract areas resulting in financial savings and efficiencies giving savings of £361k on GUM contracts.

- £1.3 million of new Public Heath investment monies has been deployed in the following areas:
  The Schools Programme for increased physical activity and improved nutrition, sexual health promotion and drug and alcohol awareness.
  The Early Years programme supported first time mothers and breastfeeding, childhood obesity and smoking cessation in pregnancy.
  Significant investment went into physical activity programmes and outdoor gyms with specialist support for older people, community emotional well being and warmer homes.

Appendix 2 Working with Councils

Since the transfer of the service, Public Health has been working with colleagues from across the two Local Authorities. The following list demonstrates our joint working, in partnership, with other directorates to deliver key projects and strategies.

Harrow

- Worked with 19 organisations/ departments from NHS, Harrow Council and Third Sector to deliver a very well attended 'Health at Work' month across the Council
- Adult Social Care Harrow Council and Harrow CCG to deliver a 1 day Dementia workshop
- Worked as part of Cross (Harrow) Council Welfare Reform Group to provide the Harrow Help scheme to support individuals with benefits problems in a holistic manner.
- Development of Obesity Strategy Group (Harrow) involving among others: Adult Social Care, Sports Development and Active Transport producing draft needs assessment.
- Job Centre Plus, Disability Advisor, Third Sector, Harrow Council policy Officer to develop approach to supporting return to work for people with health barriers.
- Harrow Council Housing – to identify suitable sites for community growing project.
- Outdoor Gyms Harrow – delivery of Activator Programme volunteers to encourage activity and advise public on use of outdoor gym equipment.
- Community pharmacies (alcohol brief advice)
- Schools – healthy eating and access to fresh fruit and vegetables
- Obesity partnership group (established it with ToR)
- Harrow Council mental health commissioning team – review mapping exercise for mental health and wellbeing strategy
- Probation – supporting Probation to enable their clients to register with GPs and in turn facilitate access to health checks.
- Adult Social care including Reablement service over Expert Patient Programme (EPP) and Long term conditions – to explore links with the EPP programme.
- Harrow Council Public Realm and Chief Execs office on Silver Star (diabetes charity) to organise and promote Diabetes week including mobile screening for individuals
- Under One Sky – worked with other organisers to define and deliver a Public Health Presence on the day. This included the launch of the gym activator programme with volunteers and outdoor gym equipment available plus other aspects of PH work.
- Safeguarding Adults
- Safeguarding Children
- Multi Agency Safeguarding Hub
- Police
- CCG Mental Health commissioner
- MOPAC

Children's Harrow

- Harrow Partnership for School Improvement – joint training for schools to obtain Healthy Schools London Award – 23 schools registered. Schools engagement has lead to further development of the programme.
- Harrow health visiting team & early years service lead – brushing for life – Children's Centre staff and Health Visitors working together on oral health for under 5s – Brushing for Life programme
- Harrow Joint Analytical group – Police, Harrow Council central performance team, Community Safety, Harrow Council Census Team to deliver various work including Vitality Profiles and the new public health information web site Harrow Informed.
- Establishing Tobacco Control Alliance - Licensing, Trading standards, Environmental Health
- Harrow house warmers programme - Climate change team – to achieve receipt of an extra £16.5k income for fuel poverty, helped 488 people overall. This help also included advocacy support, legal advice, and practical support such as haters and duvets.

Barnet

- Sports Partnership – joint planning for the Fit and Active Barnet campaign.
- Older Peoples Assembly, Adults and Communities Dept. (Barnet Council) and Third Sector organisations to develop older people's physical activity provisions.
- Barnet Council Street Scene & Adults and Community, Middlesex University, Barnet College, Saracens rugby club and Barnet Football club to deliver outdoor gyms and activators programme.
- Teachers, School Sports Partnership, PE consultants and service providers to deliver nutrition and physical activity as part of the Barnet Schools Well being programme.

Children's Barnet

- Children's Centres Managers, Early Intervention and family's team – incorporation of health priority areas in Children's Centre work.
- Dentists in Barnet – to deliver children's dental health in Children's Centres and schools – child friendly practices working closely with PHE dental health consultant - Lauren
- Barnet Partnership for School Sports (BPSS) outcome - schools access well being programme resources via vehicle they trust and are familiar with. BPSS offer increased to cover wellbeing
- Barnet Children's Services workforce development – promoting 'healthy eating' and booking training for school staff for wellbeing programme; putting 'health' on the schools agenda
- Barnet Commissioning Board – smooth processing of new investment business cases
- Harrow Council procurement – to ensure effective and timely procurement and consistency of approach

- Harrow Council Contingency planning team – delivery of the PH business continuity plan which will be used inform the corporate continuity plan.
- Barnet Council grants staff – manage part of the new investment money – going to third sector
- Legal Services - to ensure streamlined approach to contracting
- Work with Harrow Council finance to set up SAP/ budgets etc. and training for staff
- Work with Harrow Council HR re initial pay roll set up and, later, the job evaluations.

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The North West London Hospitals NHS Trust

Trust Headquarters
Northwick Park Hospital
Watford Road
Harrow
Middlesex
HA1 3UJ

20th August 2014

Dear colleagues

Following the Care Quality Commission's (CQC) inspection of the Trust in May 2014, I am writing to update you on the report and next steps. The CQC's final report was discussed at a Quality Summit hosted by the Trust on 14th August 2014 and is published on their website www.cqc.org.uk.

The CQC presents a fair reflection of the Trust. It identifies where improvements are required and also recognises areas of good performance and outstanding practice. Importantly, the report confirms the care, commitment and compassion of our staff.

A significant amount of work is already underway to improve safety and effectiveness of care in our maternity unit. Our Accident and Emergency (A&E) care will also be improved through the planned centralisation of services in North West London. In addition, a new £21m A&E department will open at Northwick Park Hospital in the autumn.

As a Trust we aspire to provide the best possible care to all of our patients. We have a good understanding of the challenges that we face and were able to highlight these to the CQC at the start of their inspection. The report reflects that, in the main, the CQC didn't find anything that we hadn't reported to them. Only one issue, in relation to critical care, had not been expected.

In most areas, our staff were seen to provide compassionate care that respected the dignity of patients. Outstanding practice was observed in the Stroke Unit and STARRS service.

The overall CQC rating for the Trust was '*Requires improvement*'. The report calls for action to be taken in the following areas:

1. Ensure that there are appropriate numbers of staff to meet the needs of patients in the A&E department, surgical areas and critical care (Northwick Park Hospital and St Mark's Hospital)
2. Ensure that there are systems in place to assess and monitor the quality of the service provided in A&E, critical care, surgery and maternity, to ensure that services are safe and benchmarked against national standards (Northwick Park Hospital)

Continued….

3. Ensure that the environment is safe and suitable in the paediatric service (Northwick Park Hospital)
4. Ensure that equipment is available, safe and suitable within the paediatric service (Northwick Park)

The work, to improve our services has already started. Some changes will happen fairly quickly others will take longer to bring about. A report, detailing the Trust's response to the CQC's findings, will be presented to the Board in October 2014 and I look forward to keeping you updated on our progress.

Yours sincerely

David McVittie
Chief Executive and Merger Transaction Director

North West London Hospitals NHS Trust

Quality Report

Watford Road
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Website: www.nwlh.nhs.uk

Date of inspection visit: 20-23 May 2014
Date of publication: 20 August 2014

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Requires improvement
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out this comprehensive inspection because North West London Hospitals NHS Trust had been identified as potentially high risk on the Care Quality Commission's (CQC) Intelligent Monitoring system.

North West London Hospitals NHS Trust is located in the London Boroughs of Brent and Harrow, and cares for more than half a million people living across the two boroughs, as well as patients from all over the country and internationally. The North West London Hospitals NHS Trust manages three main sites registered with the Care Quality Commission: Northwick Park Hospital and St Mark's Hospitals in Harrow, and Central Middlesex Hospital in Park Royal. St Mark's Hospital is an internationally-renowned centre for specialist care for bowel diseases. The trust has a sustainable clinical strategy with Ealing Hospital that improves patient pathways, underpinned by combined ICT and estate strategies, and a vision to establish Northwick Park Hospital as the major acute hospital of choice for outer North West London.

Our key findings were as follows:

- Some areas had shortages of nursing and/or medical staff, which impacted on the care being given.
- Escalation procedures were not always followed or effective.
- Maternity services continue to require improvements to ensure a cohesive, safe, effective service for women.
- There were concerns about the competency and supervision of middle grade doctors.
- Appraisal rates for staff were, in some areas, poor.
- Auditing in the critical care area was poor and was not in line with national programmes.
- Equipment and the environment, particularly in paediatric services, required improvements in order to maintain the safety of children and young people.
- Policies, procedures and protocols were not always up to date and reflective of best practice guidance.
- There was inequity in discharge arrangements.
- Most areas were clean, and at the Central Middlesex Hospital patients were complimentary about the food they received.
- Infection control practices and rates of infection were good.

We saw several areas of outstanding practice including:

- The stroke unit was providing a 'gold standard service' with seven-day working. It had been the recipient of the prize for the 2013 Clinical Leadership Team at the British Medical Journal awards.
- The STARRS service had strong ownership by geriatricians and the multi-disciplinary team. The team was aware of the needs of frail elderly patients who attend A&E. It was introduced by the trust and its partners to mitigate one of the pressures on the A&E service and the hospital's beds.

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

Importantly, the trust must:

- Ensure that there are appropriate numbers of staff to meet the needs of patients in the A&E department, surgical areas and critical care (Northwick Park Hospital and St Mark's Hospital).
- Ensure that there are systems in place to assess and monitor the quality of the service provided in A&E, critical care, surgery and maternity, to ensure that services are safe and benchmarked against national standards (Northwick Park Hospital).
- Ensure that the environment is safe and suitable in paediatric services (Northwick Park Hospital).
- Ensure that equipment is available, safe and suitable within the paediatric service (Northwick Park Hospital).

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to North West London Hospitals

North West London Hospitals NHS Trust manages Northwick Park Hospital and St Mark's Hospital in Harrow, and Central Middlesex Hospital in Park Royal. The trust employs more than 4,300 doctors, nurses, therapists, scientists and other health professionals, as well as administrative and support staff, making them one of the largest employers locally.

Northwick Park Hospital has 658 beds and runs a hyper acute stroke unit. The hospital is very busy but overall, all sites operate at below the national average bed occupancy rate, at 82.5%. Central Middlesex Hospital has 180 beds and, in general, the pressure on the beds is lower, as surgery and admissions are, to a large extent, planned. St Mark's Hospital has 64 beds and provides specialist gastro-intestinal surgery to patients, including those from abroad.

The trust has a sustainability plan, which involves merging with Ealing Hospital NHS Trust, to ensure that all hospitals are sustainable. The trust serves a population of 500,000 people across Brent and Harrow, but also sees patients from across the country and internationally through St Mark's Hospital's specialist services. In terms of deprivation, Brent is ranked 35th and Harrow 194th out of 326 local authorities. This provides a complex mix of deprivation for the trust.

We inspected North West London Hospitals NHS Trust as it was selected as a level 1 high risk trust from our CQC Intelligent Monitoring tool. Tier 1 indicators are the key metrics that CQC uses to help decide where and what to inspect. These Tier 1 indicators have been selected on the basis of statistical robustness, ability to identify poorly performing trusts, and their ability (as a group) to cover multiple dimensions of quality.

Our inspection team

Our inspection team was led by:

Chair: Alastair Henderson, Chief Executive, Academy of Medical Royal Colleges

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission

The team included eight CQC inspectors and a variety of specialists: an interim chief operating officer, consultant gastroenterologist, consultant physician, A&E consultant, clinical director of obstetrics and gynaecology, consultant anaesthetist, consultant paediatrician, a junior doctor, a matron, a critical care senior nurse manager, governance manager, health visitor, a student nurse, a pharmacist and three Experts by Experience.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG), NHS Trust Development Authority, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the royal colleges and the local Healthwatch.

We held a listening event in Wembley on 20 May 2014, when people shared their views and experiences of the trust. Some people who were unable to attend the listening events shared their experiences via email or telephone.

Summary of findings

We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at North West London Hospitals NHS Trust.

What people who use the trust's services say

CQC's Adult Inpatient Survey 2012 shows that the trust was performing the same as other trusts for nine of the 10 areas of questioning. In the individual results, the trust was performing worse than other trusts for one of the questions around 'Waiting List and Planned Admissions', three of the questions around 'The Hospital and Ward', one question around 'Nurses', one question around 'Operations and Procedures', and one question around 'Leaving Hospital'.

Since April 2013, patients have been asked whether they would recommend hospital wards to their friends and family if they required similar care or treatment, the results of which have been used to formulate NHS friends and family tests for accident & emergency and inpatient admissions. Between November 2012 and February 2014, the trust scored above the national average for inpatients and A&E patients. However, in the period January to February 2014, the trust's score in A&E dipped to below the national average.

The Cancer Patient Experience Survey is designed to monitor national progress on cancer care; 152 acute hospital NHS trusts took part in the 2012/13 survey, which consisted of a number of questions across 13 different cancer groups. Patients rated the trust as being in the bottom 20% of all trusts nationally for 35 of the 69 questions for which the trust had a sufficient number of survey respondents on which to base findings.

In CQC's maternity survey, the trust scored worse than other trusts for two out of the three areas of questioning. These included labour and birth, and staffing during labour and birth.

Facts and data about this trust

Key facts and figures about the trust

- Northwick Park - 658 Beds
- St Mark's - 64 Beds
- Central Middlesex - 180 Beds
- Inpatient admissions -107,202 2012/13
- Outpatient attendances - 343,967 2013/14
- A+E attendances - 223,343 2012/13
- Births - 5,609 Oct 12 to Nov 13
- Deaths (and by location)
- Annual turnover
- Surplus (deficit) - £20.5m deficit

Intelligent Monitoring

Safe - Risk: 2; Elevated: 0; Score 2

Effective - Risk: 2; Elevated: 0; Score 2

Caring - Risk: 2; Elevated: 3; Score 8

Responsive - Risk: 0; Elevated: 2; Score 4

Well led - Risk: 2; Elevated: 0; Score 2

Total - Risk: 8; Elevated: 5; Score 18

Individual Elevated Risks

- Maternity Survey 2013 C2 "During your labour, were you able to move around and choose the position that made you most comfortable?" (Score out of 10)

Summary of findings

- Maternity Survey 2013 C12 "Did the staff treating and examining you introduce themselves?" (Score out of 10)
- Maternity Survey 2013 C13 "Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?" (Score out of 10)
- Composite indicator: A&E waiting times more than 4 hours
- Composite indicator: Referral to treatment

Individual Risks

- 'Never event' incidence
- Potential under-reporting of patient safety incidents
- PROMs EQ-5D score: Knee Replacement (PRIMARY)
- Proportion of patients who received all the secondary prevention medications for which they were eligible
- Maternity Survey 2013 C14 "If you raised a concern during labour and birth, did you feel that it was taken seriously?" (Score out of 10)
- Maternity Survey 2013 C18 "Thinking about your care during labour and birth, were you treated with respect and dignity?" (Score out of 10)
- Healthcare Worker Flu vaccination uptake

Safe:

Never events in past year - 4

Serious incidents (STEIs) - 126 Between Dec 2012 and Jan 2014

National Reporting and Learning System (NRLS)

- Deaths - 9
- Serious - 17
- Moderate -190
- Abuse - 30
- **Total - 246**

Effective:

HSMR - No evidence of risk

SHMI - No evidence of risk

Caring:

CQC inpatient survey - **average**

Cancer patient experience survey - **below**

Responsive:

Bed occupancy - 92.9%

Average length of stay - _____

A&E: 4 hour standard - Elevated Risk

Cancelled operations - No evidence of risk

Delayed discharges - No evidence of risk

18 week RTT - Elevated Risk

Cancer wards - No evidence of risk

Well-led:

Staff survey - **average**

Sickness rate 2.9 % - **above**

GMC training survey - **below**

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? The trust requires some improvements to ensure that all patients are safe within its services. The pressures in A&E meant that some patients awaiting admission are 'bedded' down within the A&E department. This reduced the capacity of the department and impacted on the safety of these patients. Equipment was not always thoroughly checked for compliance with electrical safety measures and not entered onto the central equipment register. Lack of staff, both medical and nursing, on some ward areas meant that patients had to wait for their care needs to be met. However, the trust had invested in physiotherapy and occupational therapy support, and patients requiring these services received timely and safe care. We saw that safe and effective arrangements were in place for prescribing, ordering, storing, administering and recording of medicines. We saw medication and intravenous fluids were stored securely in all areas, except in one paediatric outpatient area at Central Middlesex Hospital. We saw that learning from medicines incidents was shared with staff through regular bulletins and learning events.	**Requires improvement** 
Are services at this trust effective? Not all policies, procedures and protocols were based on national guidance and some were out of date. This was particularly in the surgical wards and in the critical care areas. The audit undertaken in the critical care area was poorly complied with, and did not reflect national audit data. This meant that the department could not benchmark itself against others, and therefore was unaware of the effectiveness of its service. We had significant concerns around the competency of some middle grade doctors, with training and supervision being minimal in this staffing group. The trust has protected meal times, and patients in general were complimentary about the food they received. However, there were not always enough staff on duty to ensure that patients were helped to eat their meals before food went cold. Patient outcomes were monitored in most areas, and were in general positive. Most areas had good multidisciplinary working, with the only exception being the maternity unit. Services were available seven days a week, although limited at Central Middlesex Hospital.	**Requires improvement** 

Summary of findings

Are services at this trust caring?

Requires improvement

Some areas of the trust required improvements to be made in the care provided to patients. Despite the investment in staffing and processes, patients still rated maternity services as being uncaring at times. Patients reported to us, and through the maternity survey, that they felt that the staff failed to care for them as an individual. This was across both nursing and medical staff. We heard isolated fears of patients in St Mark's Hospital about the shortage of nurses and the impact that this had on care. In most areas staff were seen to provide compassionate care that respected patients' dignity. However, the maternity services and Fredrick Salmon ward in particular have affected the rating for this key question. The trust's results from the NHS Friends and Family test were below the national average.

Patients were involved in most areas in the planning of their care and treatment. 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions were discussed with all patients whom this affected. Emotional support was offered by a good chaplaincy service, and through caring and supportive nursing staff.

Are services at this trust responsive?

Requires improvement

The flow through Northwick Park Hospital was challenging, as patients from the A&E department could not always access a bed in the appropriate ward in a timely manner. Discharges were sometimes delayed due to patients not living in the area covered by the Short Term Acute Rehabilitation and Re-enablement Service (STARRS) project, or those awaiting medication to be dispensed. Some areas of the trust were dilatory in response to complaints, and staff did not always recognise the lessons to be learned from these. However, the trust is in line with national benchmarking in respect of delayed discharges, and cancelled operations, but continues to struggle to meet the four-hour A&E target.

Services were delivered to meet the needs of most of the local population in approximately half of the services. However, we found that there was a lack of understanding from staff about the future of the services and their hospitals. This was despite the trust having a communication strategy in place. Care bundles and audits were in place in most areas to ensure that patients received treatment that delivered positive outcomes. However, areas such as St Mark's Hospital and the critical care unit did not have positive clinical audits to effectively measure and benchmark performance.

Are services at this trust well-led?

The trust's leadership are aware of the issues they face at the three hospitals. There is a good level of confidence in the CEO and most of the senior team. We found that locally, the leadership of the core

Summary of findings

services, in the main, required improvements to be made in respect of the management of departments and wards. There was a lack of clear understanding by staff regarding the strategy and vision of the proposals for the upcoming merger with Ealing Hospital. Staff remained concerned at the impact that this would have on their services. This was evident in all areas, despite the trust having issued a significant amount of literature about the merger, and it remained an unclear picture throughout our inspection.

Risk management strategies and governance processes were not yet embedded, and this in itself poses a risk for the trust. While the trust's senior management team were aware of most of the issues, we found that they were unaware of the issues within critical care, and lacked focus on how slow human resource processes had affected staff members. The lack of an escalation policy in maternity and in A&E impacted on the safety and effective treatment of patients in these areas. The trust was aware of these issues, but they were not resolved at the time of our visit.

Vision and strategy for this trust

- The trust was aware of the issues it faces. However, we found that consistent delays and uncertainty over the merger with Ealing have created a planning blight.
- There seems little real understanding or even belief in the reality of the merger and its implications among the body of staff.

Governance, risk management and quality measurement

- The trust was aware of the risks it faces, and has some systems to monitor these.
- The governance framework was relatively new to the organisation, and this had not properly embedded at the time of our visit.
- The trust was unaware of the issues within the critical care arena. While these did not directly impact upon the care for patients, the support mechanism and monitoring data were not adequate to promote safety and improvement within the service.
- Lack of escalation within the maternity service meant that risks could not be addressed.
- Staff did not always receive timely feedback on incidents reported.

Summary of findings

Leadership of trust

- The leaders of the organisation were well known to the staff body. However, they were less visible at Central Middlesex Hospital.
- There is a good level of confidence in the Chief Executive, new medical director and Board Chairman.
- Middle managers felt that they were unable to make improvements to the quality of care they provided.
- Some medical and nursing staff felt undervalued by the trust. This was particularly evident at both St Mark's Hospital and Central Middlesex Hospital.

Culture within the trust

- There was little sense of cohesion among the three hospitals that make up the trust. We heard staff refer to "them up there" or "down here"
- Most staff reported that they felt supported by their line managers and senior managers.
- We heard about a couple of grievance/disciplinary cases which had taken over two years to resolve.
- Staff attitudes were good and staff have considerable pride in their hospital and the services provided.
- The presence of St Mark's Hospital gives the trust organisational status and pride.
- There were some examples of bullying behaviour reported to us, which some staff accepted as the norm.

Public and staff engagement

- The trust has published approximately 150 documents relating to the proposed merger. On review of two of these that were available in public areas for staff and patients, only very high level information was provided.
- Staff told us they were sent daily emails and the chief executive's bulletin in order to update them on trust developments. However, some staff reported that they did not read these.
- Various staff groups reported that they had attended open forum meetings with the chief executive, and that the management of the trust were approachable and responsive.
- Staff were aware of the distribution of trust information via a briefing called 'Team Talk' on the intranet, and also the hospital magazine, which was produced quarterly.
- Some more senior staff felt involved in the proposed merger.
- Staff reported that they felt that it was difficult to be heard at trust board level.

Summary of findings

- There was a positive feedback from doctors in training on their experience at the trust. It was regarded a good training placement with high quality supervision and a good range of training experiences. The focus groups we attended stated that the trust was rated positively in comparison to other London teaching placements.

Innovation, improvement and sustainability

- The trust has published approximately 150 documents relating to the proposed merger. On review of two of these that were available in public areas for staff and patients, only very high level information was provided.
- Staff told us they were sent daily emails and the chief executive's bulletin in order to update them on trust developments. However, some staff reported that they did not read these.
- Various staff groups reported that they had attended open forum meetings with the chief executive, and that the management of the trust were approachable and responsive.
- Staff were aware of the distribution of trust information via a briefing called 'Team Talk' on the intranet, and also the hospital magazine, which was produced quarterly.
- Some more senior staff felt involved in the proposed merger.
- Staff reported that they felt that it was difficult to be heard at trust board level.
- There was a positive feedback from doctors in training on their experience at the trust. It was regarded a good training placement with high quality supervision and a good range of training experiences. The focus groups we attended stated that the trust was rated positively in comparison to other London teaching placements.
- The trust has a sustainability plan, but this is not known among staff, despite approximately 150 communications to the staff. Staff were concerned about their futures within the services they provided.
- As a result of the success of the study undertaken by the specialist palliative care team two Darzi fellows were secured to lead a service development programme to reduce the number of admissions to hospital for patients with long-term conditions, or who were frail in the last years of their life.
- A good example of innovation was the jointly-created integrated care plan for asthma care, developed with GPs. This had been shown to reduce A&E attendance by half, and reduced admissions by one third.

Summary of findings

- The stroke unit was providing a ‘gold standard service’ with seven-day working. It had been the recipient of the prize for the 2013 Clinical Leadership Team at the British Medical Journal awards.

Overview of ratings

Our ratings for Northwick Park Hospital:

	Safe	Effective	Caring	Responsive	Well-led	Overall
A&E	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Inadequate	Good	Requires improvement	Inadequate	Inadequate
Maternity & Family planning	Requires improvement	Requires improvement	Inadequate	Requires improvement	Requires improvement	Requires improvement
Children & young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Good	Good	Good
Outpatients	Requires improvement	Not rated	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement

Our ratings for Central Middlesex Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
A&E	Good	Not rated	Good	Good	Good	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Children & young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Good	Good	Good

Overview of ratings

Outpatients	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Requires improvement	Good

Our ratings for St Mark's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement
Outpatients	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement

Our ratings for North West London Hospitals NHS Trust

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and emergency, and Outpatients.

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of outstanding practice including:

- The stroke unit was providing a 'gold standard service' with seven-day working. It had been the recipient of the prize for the 2013 Clinical Leadership Team at the British Medical Journal awards.
- The STARRS service had strong ownership by geriatricians and the multi-disciplinary team. The team was aware of the needs of frail elderly patients who attend A&E. It was introduced by the trust and its partners to mitigate one of the pressures on the A&E service and the hospital's beds.

Areas for improvement

Action the trust MUST take to improve

- Ensure that there are appropriate numbers of staff to meet the needs of patients in the A&E department, surgical areas and critical care (Northwick Park Hospital and St Mark's Hospital).
- Ensure that there are systems in place to assess and monitor the quality of the service provided in A&E, critical care, surgery and maternity, to ensure that services are safe and benchmarked against national standards (Northwick Park Hospital).
- Ensure that the environment is safe and suitable in paediatric service (Northwick Park Hospital).
- Ensure that equipment is available, safe and suitable within the paediatric service (Northwick Park Hospital).

North West London Hospitals NHS Trust

Central Middlesex Hospital

Quality Report

Acton Lane
Park Royal
London
NW10 7NS
Tel: 020 8869 3493
Website: www.nwlh.nhs.uk

Date of inspection visit: 20-23 May 2014
Date of publication: 20 August 2014

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Good
Accident and emergency	Good
Medical care	Good
Surgery	Good
Critical care	Requires improvement
Services for children and young people	Requires improvement
End of life care	Good
Outpatients	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out this comprehensive inspection because North West London Hospitals NHS Trust had been identified as potentially high risk on the Care Quality Commission's (CQC) Intelligent Monitoring system. We undertook an announced inspection between 20 and 23 May 2014.

North West London Hospitals NHS Trust is located in the London Boroughs of Brent and Harrow, and cares for more than half a million people living across the two boroughs, as well as patients from all over the country and internationally. The North West London Hospitals NHS Trust manages three main sites registered with the Care Quality Commission: Northwick Park Hospital and St Mark's Hospital in Harrow, and Central Middlesex Hospital in Park Royal. St Mark's Hospital as an internationally-renowned centre for specialist care for bowel diseases. The trust has a sustainable clinical strategy with Ealing Hospital to improve patient pathways, underpinned by combined ICT and estate strategies, and a vision to establish Northwick Park Hospital as the major acute hospital of choice for outer North West London.

The services provided at Central Middlesex Hospital were rated as good, apart from critical care and services provided for children and young people. This was due to the lack of paediatric nurses and equipment available in the outpatients clinics. The new building provided good facilities and enhanced the way staff felt about providing good care. However, there was a general concern among staff about the future of the hospital.

Our key findings were as follows:

- Staff were caring and provided individualised care to patients.
- The hospital was clean, and patients were complimentary about the food provided.
- Staffing levels were sufficient in most areas for care to be given in a timely manner.
- Outpatient facilities for children were not utilised, and paediatric nurses were not available in the outpatients department.
- A&E services were a mixture of acute A&E services and a minor injuries unit. This could lead to confusion for the local population as to the services provided on site at any particular time.
- Staff felt disconnected with the main trust site.

We saw an area of outstanding practice including:

- The STARRS service had strong ownership by geriatricians and the multi-disciplinary team. The team was aware of the needs of frail elderly patients who attend A&E. It was introduced by the trust and its partners to mitigate one of the pressures on the A&E service and the hospital's beds.

There were areas of poor practice, where the trust needs to make improvements.

The trust should:

- Review the lack of a paediatric nurse in the children's outpatient department.
- Ensure that critical care services are audited in line with others, so that benchmarking can take place to drive improvement.
- Review the end of life care provision at this hospital, so that patients receive intervention at an appropriate stage.
- Ensure that departments where children are treated are child-friendly.
- Review epilepsy services for children to ensure that current guidance is in place.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Accident and emergency	Good	The A&E department provided care and treatment that was safe. Completed incident reports had a clear 'lessons learned' approach. Equipment was clean and maintained to the manufacturer's recommendations, with service labels highlighting when the next service was due. Medication was recorded and stored appropriately, with daily checks carried out by qualified staff. Staff had received mandatory training, including safeguarding vulnerable adults and children. Mental capacity assessments were undertaken appropriately and staff demonstrated knowledge around the trust's policy and procedures. Staff took the time to listen to patients and explain to them what was wrong, and any treatment that was required. Patients told us that they had all their questions answered, and felt involved in making decisions about their care. Staff expressed pride to be working in the A&E department.
Medical care	Good	Central Middlesex Hospital provided safe care to its patients. There were enough medical and nursing staff to ensure that patients received appropriate care and treatment. Staff in medical services were caring and compassionate, and responded to patients' needs effectively. Patients, and those close to them, were complimentary about the way that staff cared for them, and they felt respected by staff. There were enough medical and nursing staff to ensure that patients received appropriate care and treatment, and staff told us that they worked in supportive teams. Patients were able to access medical services in a way that was convenient for them. Staff had received appropriate training to meet the needs of the community, including training in equality and diversity, and dementia. The medical service had clear line management arrangements.

Summary of findings

Surgery	**Good**		Surgical services provided safe and effective care in the areas we visited. There were appropriate numbers of nursing and medical staff, and staff followed guidance when providing care and treatment. Staff were caring and supportive of patients, and made efforts to keep them involved in decisions about their care and treatment. Arrangements were in place to accommodate the different religious and cultural needs of patients. There was usually a suitable flow of patients through the department. However, there were isolated issues relating to inadequate pre-assessments prior to patients being admitted to the department. There were suitable arrangements in place to monitor the quality and safety of the service.
Critical care	**Requires improvement**		The critical care services at Central Middlesex Hospital require improvement. There were appropriate numbers of suitably-trained staff, who worked according to procedures to keep people safe. Staff collected ongoing data on the safety and performance of the department, which indicated positive patient outcomes. Staff were caring towards patients, and were able to respond to fluctuations in demand. However, governance arrangements could be improved, as could the strategy and vision for the department as a whole. While morale within the team was positive, it was not clear how the unit linked with the trust-wide department as a whole.
Services for children and young people	**Requires improvement**		The day surgery unit and the Rainbow Children's Centre at this site was very differently managed from Northwick Park Hospital. The day surgery unit offered good information for families and children before procedures, had good processes and protocols, and families were pleased with the service. By contrast, the outpatient clinics run by the Rainbow Children's Centre gave us cause for concern, because there was no registered children's nurse, and there were some poor practices around medicines management. The clinics were not child-friendly and lacked play facilities.
End of life care	**Good**		We found that the end of life care to patients was good overall. The hospital had good links with the

Summary of findings

			specialist palliative care team (SPCT) and community services to support patients and their families. The SPCT and other services involved in end of life care were passionate, caring and maintained patients' dignity throughout their care. There was clear multidisciplinary involvement in patient care. Patients were involved in advance care planning and their preferences were observed and followed through, when possible and appropriate. People's cultural and religious needs were taken into account. End of life care training was not mandatory within the trust, and this meant that healthcare professionals at the hospital found it difficult to attend the courses provided by the SPCT.
Outpatients	**Good**		Patients received compassionate care and staff treated them with dignity and respect. The environment was clean, comfortable, well maintained and safe. Staff were professional and polite, and promoted a caring ethos. Clinicians took sufficient time in consultations, and patients said that they felt involved in their care. Clinics started on time and generally ran to schedule. The rheumatology clinics were regularly oversubscribed and had long waiting times, but action was being taken to recruit an additional consultant.

Good

Central Middlesex Hospital

Detailed findings

Services we looked at
Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Services for children and young people; End of life care; and Outpatients

Contents

Detailed findings

Background to Central Middlesex Hospital

Central Middlesex Hospital is part of North West London Hospitals NHS Trust and has 180 beds. This CQC inspection was not part of an application for foundation trust status. The trust is currently undergoing a merger with Ealing Hospital NHS Trust, which is scheduled to become effective in October 2014.

Central Middlesex Hospital is in the London Borough of Brent, which is a densely populated multi-cultural, outer London borough located in the north west of London. The population of Brent is 311,215 as recorded in the 2011 Census. The GP registration data shows that the percentage of the population registered with a GP in Brent is 82.4%. Of 326 local authorities, Brent is the 35th most deprived. In Brent, 63.7% belong to non-White minorities. Of these, the Asian ethnic group constitutes the largest ethnic group with 34.1% of the population.

Over the last 10 years in Brent, all-cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen. Life expectancy for both men and women is higher than the England average. Life expectancy is also 8.8 years lower for men in the most deprived areas of Brent than in the least deprived areas.

The trust was selected for inspection as an example of a 'high risk' trust.

Our inspection team

Our inspection team was led by:

Chair: Alastair Henderson, Chief Executive, Academy of Medical Royal Colleges

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission (CQC)

The team included CQC inspectors and analysts, doctors, nurses, patient 'experts by experience' and senior NHS managers.

How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Services for children and young people
- End of life care
- Outpatients

Before visiting, we reviewed a range of information we hold about the hospital, and asked other organisations to share what they knew about the hospital. We carried out an announced visit on 21 and 22 May 2014. During the visit we held focus groups with a range of staff in the hospital, including doctors, nurses, allied healthcare professionals and healthcare assistants. We also interviewed senior members of staff at the hospital.

We talked with patients and staff from various areas of the hospital, including the wards, outpatients department and the A&E department. We observed how patients were being cared for, and talked with carers and/or family members and reviewed treatment records of patients. We held a listening event where patients and members of the public shared their views and experiences of the hospital.

Detailed findings

Facts and data about Central Middlesex Hospital

Key facts and figures about the trust

- Beds - 180 Beds
- Inpatient admissions -107,202 2012/13
- Outpatient attendances - 343,967 2013/14
- A+E attendances - 223,343 2012/13
- Births - 5,609 Oct 12 to Nov 13
- Deaths (and by location)
- Annual turnover
- Surplus (deficit) - £20.5m deficit

Intelligent Monitoring

Safe - Risk: 2; Elevated: 0; Score 2

Effective - Risk: 2; Elevated: 0; Score 2

Caring - Risk: 2; Elevated: 3; Score 8

Responsive - Risk: 0; Elevated: 2; Score 4

Well led - Risk: 2; Elevated: 0; Score 2

Total - Risk: 8; Elevated: 5; Score 18

Individual Elevated Risks

- Maternity Survey 2013 C2 "During your labour, were you able to move around and choose the position that made you most comfortable?" (Score out of 10)
- Maternity Survey 2013 C12 "Did the staff treating and examining you introduce themselves?" (Score out of 10)
- Maternity Survey 2013 C13 "Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?" (Score out of 10)
- Composite indicator: A&E waiting times more than 4 hours
- Composite indicator: Referral to treatment

Individual Risks

- 'Never event' incidence
- Potential under-reporting of patient safety incidents
- PROMs EQ-5D score: Knee Replacement (PRIMARY)
- Proportion of patients who received all the secondary prevention medications for which they were eligible
- Maternity Survey 2013 C14 "If you raised a concern during labour and birth, did you feel that it was taken seriously?" (Score out of 10)
- Maternity Survey 2013 C18 "Thinking about your care during labour and birth, were you treated with respect and dignity?" (Score out of 10)
- Healthcare Worker Flu vaccination uptake

Safe:

Never events in past year - 4

Serious incidents (STEIs) - 126 Between Dec 2012 and Jan 2014

National Reporting and Learning System (NRLS)

- Deaths 9
- Serious 17
- Moderate 190
- Abuse 30
- **Total 246**

Effective:

HSMR - No evidence of risk

SHMI - No evidence of risk

Caring:

CQC inpatient survey - **average**

Cancer patient experience survey - **below**

Responsive:

Bed occupancy - 92.9%

Average length of stay - _____

A&E: 4 hour standard - Elevated Risk

Cancelled operations - No evidence of risk

Delayed discharges - No evidence of risk

18 week RTT - Elevated Risk

Cancer wards - No evidence of risk

Well-led:

Staff survey - **average**

Sickness rate 2.9 % - **above**

GMC training survey - **below**

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and Emergency, and Outpatients.
2. We have not reported on maternity and family planning at Central Middlesex Hospital. There is a satellite antenatal clinic at the hospital. A brief visit to the clinic did not identify any concerns. The clinic was assessed as good in all areas, but there was insufficient detail to merit a report. High risk mothers are referred to Northwick Park Hospital.

Accident and emergency

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

Information about the service

The accident and emergency department (A&E) at Central Middlesex Hospital provides a service to the local population between the hours of 8am and 7pm seven days a week. Outside of these hours the unit functions as a medical assessment unit (MAU). The department sees around 14,429 patients a year. A purpose-built A&E department is due to open later in 2014 on the Northwick Park Hospital site.

The A&E department has facilities for assessment, treatment of major injuries and a resuscitation area. There is an acute clinical decision unit (ACDU) within the A&E department, for which patients are admitted for up to 24 hours. Patients with minor injuries requiring urgent care are assessed by the Urgent Care Centre, which is run by an independent provider.

Our inspection included one day in the A&E department as part of an announced inspection. During our inspection, we spoke with clinical and nursing leads for the department. We spoke with two members of the medical team, and seven members of the nursing team. We also spoke with three patients and undertook general observations within all areas of the department. We reviewed the medication administration and patient records for patients in the A&E department.

Summary of findings

The A&E department provided care and treatment that was safe. Completed incident reports had a clear 'lessons learned' approach. Equipment was clean and maintained to the manufacturer's recommendations, with service labels highlighting when the next service was due. Medication was recorded and stored appropriately, with daily checks carried out by qualified staff.

Staff had received mandatory training, including safeguarding vulnerable adults and children. Mental capacity assessments were undertaken appropriately, and staff demonstrated knowledge around the trust's policy and procedures.

Staff took the time to listen to patients, and explain to them what was wrong and any treatment that was required. Patients told us that they had all their questions answered and felt involved in making decisions about their care. Staff expressed pride to be working in the A&E department.

Accident and emergency

Are accident and emergency services safe?

Good

The A&E department had systems in place to protect patients and maintain their safety. The department, including the resuscitation area and acute clinical decision unit, was clean, bright and contained adequate disposal bins for clinical and domestic waste. There were adequate staffing levels to provide safe care to patients within the treatment areas and within the acute clinical decision unit. Staff we spoke with had knowledge of the department's practices and the demands placed upon it. The transition of patients from the minor injury/Urgent Care Centre to the A&E department was smooth, with no interruption to patient-centred care.

Incidents

- The trust reported 41 serious incidents (SI) to both the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (STEIS) relating to the A&E departments between December 2012 and January 2014. This included one SI from Central Middlesex A&E department involving an ambulance delay in taking handover of care from the ambulance service.
- Staff told us that they reported incidents via the hospital's internal electronic reporting system, and received feedback on the closure of incidents they had reported.
- We spoke with senior nursing staff who could demonstrate evidence of learning from incidents. For example, ambulances waiting to handover in the A&E department at Central Middlesex Hospital had to wait within the corridor in the major's area and, at times, could not be seen. The department has now moved the ambulance triage area in front of the nurse's station and reception in the major's area, which was a safer environment and was visual reminder to staff that ambulances were waiting.

Cleanliness, infection control and hygiene

- During our inspection we observed all grades of staff using personal protective equipment (gloves, aprons, etc.) as appropriate, and washing their hands between dealing with patients.
- The trust's infection rates for C. difficile and MRSA lie within a statistically-acceptable range for the size of the trust.
- There were hand cleaning stations within all treatment areas, including the acute clinical decision unit. Hand sanitizers were found at each door entrance, and at each individual treatment cubicle.
- Staff demonstrated good underpinning knowledge of the five stages of hand cleaning and aseptic technique with regards to wound management.
- The A&E department, including the resuscitation area and acute clinical decision unit, was clean, bright and contained adequate disposal bins for clinical and domestic waste.

Environment and equipment

- The A&E department will be re-locating to a new purpose-built and designed building later in 2014, at Northwick Park Hospital.
- The resuscitation area was clean and bright. Resuscitation equipment was available and clearly identified, and followed a system that adopted an airway, breathing and circulation management approach within each resuscitation bay. Although the A&E department at Central Middlesex Hospital did not offer a children's A&E service, we saw a bed space within the resuscitation area, which had a specific cubicle with a children's resuscitation equipment trolley to deal with unforeseen emergencies.
- Treatment cubicles and bed spaces within the acute clinical decision unit were clean and well equipped with appropriate lighting.
- Equipment across all areas within the A&E department showed that there was consistency with regards to scheduled servicing. We noted that servicing of equipment was identified through the trust's internal service stickers on each piece of equipment.

Medicines

- During our inspection we checked the records and stock of medication, including controlled drugs, and found correct and concise records, with appropriate daily checks carried out by qualified staff permitted to perform this task.
- Patient prescription charts were completed and signed by the prescriber and by the nurse administering the medication.

Accident and emergency

Records

- We looked at over five sets of patients' records during our inspection. All had completed patient observations with regular re-assessments recorded.
- We observed that patients' records in A&E were kept safe and secure. Records were easily defined between clinical observations and nursing/medical notes.
- Records showed that risk assessments were undertaken in the department when patients were there for some time (it is recommended by the Royal College of Nursing that if patients are in an area for longer than six hours a risk assessment for falls and pressure ulcers should be completed).

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were knowledgeable about how to support patients who lacked capacity. They were aware of the need to assess whether a patient had a temporary or permanent loss of capacity, and how to support patients in each situation. If there were concerns regarding a patient's capacity, the staff ensured that the patient was safe and then undertook a mental capacity assessment.
- According to the A&E mandatory training database, all nursing and medical staff had undertaken training in the Mental Capacity Act (2005).
- We observed nursing and medical staff obtaining consent from patients prior to any care or procedure being carried out.
- Staff gained assistance and advice from mental health services as appropriate in a timely manner.

Safeguarding

- Training records showed that all nursing and medical staff had undergone mandatory safeguarding training at an appropriate level.
- All safeguarding concerns were raised through a robust internal reporting system. The concerns were reviewed at a senior level to ensure that a referral had been made to the local authority's safeguarding team.
- The staff we spoke with were aware of how to recognise the signs of abuse, and the reporting procedures in place within their respective areas.

Mandatory training

- We were provided with comprehensive records of mandatory and supplementary training for all nursing and medical staff, with 100% compliance across the multi-disciplinary teams.
- Mandatory training was provided in different formats, including face-to-face classroom training and e-learning (e-learning is electronic learning via a computer system).
- During our inspection we noted a poster displayed within the nurse's station, stating that there was an opportunity for all staff to place their name down to attend professional development training in their clinical area. Both medical and nursing staff delivered and attended these training sessions.

Management of deteriorating patients

- The A&E department operated a 'track and trigger' alert system, whereby nurses entered the patient's clinical observations into their records. The system then provided a score which was used to alert clinicians of any deterioration in a patient's condition.
- The department operated a triage system of patients presenting to the department, either by themselves or via ambulance, and were seen in order of priority dependent on their condition.
- Patients arriving as a priority call (blue light) were transferred immediately through to the resuscitation area. Such calls were phoned through in advance (pre-alert) so that an appropriate team were alerted and prepared for their arrival.

Nursing staffing

- Information provided by the trust indicated that the A&E department was operating with the correct number of nursing staff within the correct skill sets. Senior staff told us that they were looking at the Royal College of Nursing's policy to determine whether their current staffing reflected it.
- The department had sufficient whole time equivalent (WTE) of nurses with specific paediatric qualifications should the need arise. In order to ensure that they utilised these skills, staff rotated between all areas within the A&E departments, at both Northwick Park Hospital and Central Middlesex Hospital.
- We observed that there was a professional handover of care between each shift.
- All bank and agency staff received a local induction prior to starting their shift.

Accident and emergency

Medical staffing

- The A&E department shared its consultants with Northwick Park Hospital on a rotation basis. Senior doctors were present in the department from 8am until midnight. There were middle grade and junior doctors on duty overnight, with consultants on-call.
- There was a high use of locum middle grade doctors, of which the senior management team were aware. This was particularly true at weekends and out of hours.
- The doctor's rota showed that the locum middle grade doctor use was consistent in using the same doctors who had received the trust induction programme, and were familiar with the department and protocols.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

The A&E services had appropriate policies and protocols in place to ensure effective services. However, we found little evidence that the results of audits were used to improve care within the department. Patients' needs were met by trained and competent staff. Readmission rates were above the national average and out-of-hours services were difficult to access. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for A&E.

Evidence-based care and treatment

- Departmental policies were easily accessible, which staff were aware of and reported that they used. There was a range of A&E protocols available which were specific to the department. Further trust guidelines and policies were available to staff within the A&E department. For example, there were policies on sepsis, needle stick injuries and the stroke pathway.
- There were treatment plans which were based on the National Institute for Health and Care Excellence (NICE) guidelines.
- We found reference to the College of Emergency Medicine (CEM) standards, and spoke with medical staff who demonstrated knowledge of these standards.

Care plans and pathway

- There was a clear protocol for staff to follow with regards to the management of stroke, fractured neck of femur and sepsis. The department had introduced the 'Sepsis Six' interventions to treat patients. 'Sepsis Six' was the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis.
- Nurses at the A&E at Central Middlesex Hospital were able to obtain blood cultures from patients who were suspected to be septic, and therefore were not reliant on doctors to perform this task. A senior nurse told us that this benefited patients, because they were able to be prescribed antibiotics sooner than would otherwise be the case.

Nutrition and hydration

- Nurses in the department carried out intentional care and comfort rounds every two hours with patients, and these included nutrition and hydration.
- Patients admitted within the department were offered food at regular intervals.

Patient outcomes

- Although we were informed that the department took part in national College of Emergency Medicine (CEM) audits, they were unable to provide us with the results of these, or evidence that they had used the results to assess the effectiveness of the department.
- The CEM recommends that the unplanned re-admittance rate within seven days for A&E should be between 1-5%. The national average for England is around 7%. The trust had not consistently performed well against unplanned re-admittance since January 2013. Their rate in December 2013 was 11%. This information was not broken down for each individual A&E department.

Competent staff

- 100% of appraisals of both medical and nursing grades had been undertaken, and staff spoke positively about the process and that it was of benefit.
- We saw records that demonstrated 100% of both medical and nursing staff were revalidated in basic, intermediate and advanced life support.
- We spoke with staff and students who told us that the acute clinical decision unit is an effective area for teaching and learning.

Accident and emergency

Multidisciplinary working

- We witnessed comprehensive multidisciplinary team (MDT) working within the A&E department. Medical and nursing handovers were undertaken separately. Nursing handovers occurred twice a day, and staffing for the shifts were discussed, as well as any high risk patients or potential issues. Medical handover occurred twice a day and was led by a consultant.
- There was a clear professional conjoined working relationship between the A&E department and other allied healthcare professionals within other departments. For example, the trust had a service known as the Short Term Acute Rehabilitation and Re-enablement Service (STARRS). The STARRS service consisted of therapists and nurses who visited the A&E department daily to provide intervention from community services that would enable patients to be discharged home with an appropriate care package and support. The STARRS service was praised by staff, and we saw the service being used during our inspection with a positive effect and patient's outcome.
- Staff we spoke with were aware of the protocols to follow and key contacts with external teams.

Seven-day services

- There was a consultant out-of-hours service provided via an on-call system.
- The A&E department offered all services where required between the hours of 8am and 7pm, seven days a week.
- We were told by senior staff within the A&E department that external support services were limited out of hours, and it often proved difficult at weekends to access these. This had a negative effect on patient discharges and care packages.

Are accident and emergency services caring?

Good

Evidence provided from both prior to our inspection, and from speaking to patients during our inspection, provided us with sufficient assurance that the A&E department at Central Middlesex Hospital was providing a consistently caring service.

The department had worked hard to increase the Friends and Family Test (FFT) response rate. During our inspection we found the FFT questionnaires in a prominent area in view, within the ambulance triage and reception areas.

We witnessed many episodes of caring interactions between patients and staff during our visit. Patients and relatives gave universally positive feedback about their experiences of care.

Compassionate care

- We witnessed multiple episodes of patient and staff interaction, during which staff demonstrated caring and compassionate attitudes towards patients.
- The trust was performing above the England average in the NHS Friends and Family Test in the A&E department, with a score of 65.
- Staff were knowledgeable about the care pathways available to patients.
- We observed that nurses spent time at the patient's bedside explaining what was going to happen during their stay, and answering questions from relatives in a caring and compassionate manner.
- Patients told us that staff dealt with their needs quickly, and were polite when speaking to them.

Patient understanding and involvement

- Patients told us that they felt informed about their treatment plan, and that staff were responsive to their needs. We observed staff explaining to patients if there was going to be a delay in seeing a doctor, what the reason for that delay was, and how long they would have to wait to be seen.
- Patients and relatives said that they would recommend the service to family and friends.
- A patient's relative who told us, "the care was marvellous and everything has been explained in detail".

Emotional support

- We witnessed staff providing patients and relatives with emotional support.
- There were specific information and support services available for relatives following the death of a child.

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

(for example, to feedback?)

Accident and emergency

Good

The A&E department was managed well when coping with increased activity, which occurred on a regular basis. The escalation protocol was appropriate, and provided a measurably safe response, as evidenced by patients not waiting above fifteen minutes within the ambulance triage area whilst ambulances were waiting to handover.

Major incident plans were available and practiced in line with trust recommendations.

Service planning and delivery to meet the needs of local people

- The A&E department had an escalation policy which was developed by the management team.

Access and flow

- During periods of high demand, the department was managed proactively by the A&E senior nursing team. There was clear co-ordination within the teams, which achieved a better patient experience and flow through the department.
- The trust was rated within expectations with regards to patient's transition from the ambulance to the A&E department. However, there was a significant contributing factor with regards to proactive bed management that inhibits patient flow and causes consistent ambulance handover delays.
- The trust has struggled to maintain the 95% A&E waiting time target, and many times had been below the England average. The lowest was 84% in April 2013.
- The trust was performing worse than the England average for the percentage of emergency admissions via the A&E department waiting 4-12 hours from the decision to admit until being admitted. In February 2014 the trust was performing at 15% with the England average being 6%.
- The national average for the percentage of patients that left the department before being seen (recognised by the Department of Health as potentially being an indicator that patients were dissatisfied with the length of time they were having to wait) was between 2-3% (December 2012 – November 2013); the A&E departments were at 2% in November 2013 with the highest percentage being 2.5% in April 2013. There was no breakdown of this information for each individual A&E department within the trust.
- Senior staff within the department knew who should be contacted when there were delays to patient flow.

Meeting people's individual needs

- A translation telephone service was available so that patients who were unable to speak English were able to communicate with staff. Within the department, it was possible to request a translator, and staff were aware of this service.
- There were multiple information leaflets available for many different minor injuries. These were available in all of the main languages spoken in the local community.
- The department had designated 'champions' who led on specific areas to facilitate people's individual needs. For example, there were 'champions' for learning disabilities, mental capacity and dementia.
- The department provided a relatives room. This room was adequate for its purpose, and provided relevant information, was comfortable and its décor was appropriate.

Learning from complaints and concerns

- The A&E department promoted the Patient Advice and Liaison Service (PALS), which was available in the hospital. Information was available for patients on how to make a complaint and how to access the service.
- All concerns raised were investigated, and there was a centralised recording tool in place to identify any trends emerging.
- We were told that learning from complaints was disseminated to the team during team meetings, in order to improve patient experience within the department.

Are accident and emergency services well-led?

Good

Local leadership within the A&E department was good, although there was a lack of understanding of the vision for these services in the future. Universally, throughout the

Accident and emergency

department, there was an acceptance of change, but staff were apprehensive about the forthcoming new A&E department. However, the staff we spoke with did demonstrate an attitude of commitment.

There was a clear demonstrable respect within the teams for the senior nurses and the decisions that they made in the day-to-day running of the department. We saw a good ethos of team working, and staff morale was good.

Vision and strategy for this service

- The future vision for the department was not well described by all staff members. Staff told us that there was a lack of information provided with regards to the new A&E department at Northwick Park Hospital.
- Not all staff that we spoke with were knowledgeable about the trust's vision and journey. This was despite information being available to all staff, in different formats, about the trust's vision and strategy. However, staff were aware of the priorities for the department.
- Staff were provided with updates on any changes to the department's priorities, and its performance against those priorities.
- The transition pathway for patients using the GP-led minor injuries/Urgent Care Centre and the majors A&E service was seamless, and provided a good experience for patients.

Governance, risk management and quality measurement

- Monthly departmental meetings were held. We were provided with minutes of the meetings held over the past six months. There was a set agenda for each of these meetings, with certain standing items, including case reviews, audit analysis and incident reports feedback. Top risks were discussed, including what was being done to mitigate the risks.
- A quality dashboard with up-to-date information was displayed within the A&E department. The board was displayed in an area available for the public and staff to see.

Leadership of service

- There was a strong departmental team, which was respected and led by the senior nurses.
- The management team demonstrated knowledge of the multidisciplinary teams across all grades of staff, and had a passion to drive their team from within. Members of the management team knew the key performance indicators and objectives for the A&E department.

Innovation, learning and improvement

- The department created an environment in which to learn. We spoke with junior doctors and student nurses who told us that their experiences within the A&E department were good, and that they were provided with quality mentoring and teaching time.

Medical care (including older people's care)

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

Information about the service

Central Middlesex Hospital is part of the North West London Hospitals NHS Trust. The location's medical care services include an acute admissions unit (AAU) (Roundwood), a coronary care unit (CCU), medical wards for older people (Gladstone 1, 2 and 3), and a rehabilitation ward (Gladstone 4), which is for older people recovering from orthopaedic surgery.

We spoke with 16 patients, three relatives and 28 staff, including consultants, doctors, nurses, other healthcare specialists and support staff. We observed care, and looked at the care records of 16 acute and medical patients. We reviewed other documentation, including performance information provided by the trust. We received comments from patients and those close to them, and from people who contacted us to tell us about their experiences.

Summary of findings

Central Middlesex Hospital provided safe care to its patients. There were enough medical and nursing staff to ensure that patients received appropriate care and treatment. Staff in medical services were caring and compassionate, and responded to patients' needs effectively. Patients and those close to them were complimentary about the way that staff cared for them, and they felt respected by staff. Staff told us that they worked in supportive teams.

Patients were able to access medical services in a way that was convenient for them. However, there were delays to patients' treatment when a surgical consultation was required. Staff had received appropriate training to meet the needs of the community, including equality and diversity, and dementia training. The medical service had clear line management arrangements.

Medical care (including older people's care)

Are medical care services safe?

Good

Central Middlesex Hospital provided safe care to its patients. Patients consent was sought before care and treatment were provided. A recent medication error was rectified promptly, and the patient had not been affected. There was openness and transparency when things went wrong, and information had been cascaded down to frontline staff following multidisciplinary meetings.

Staff knew how to raise concerns and make safeguarding referrals. Some staff had knowledge of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. The wards were clean and uncluttered. Equipment was appropriately checked and cleaned, and had been serviced regularly to ensure that it was working effectively.

Incidents

- No 'never events' or serious incidents had been reported for medical services in the period from December 2012 to January 2014. ('Never events' are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.)
- All staff we spoke with said that they were encouraged to report incidents. There was openness and transparency when things went wrong. Themes from incidents were discussed at weekly safety meetings.
- Staff were able to give us examples where practice had changed as a result of incident reporting. For example, there was a near miss medication error, described below under 'medicines'. The error was discovered the same day and the patient was not affected. Staff were reminded to be extra vigilant, and appropriate action was taken by the trust. We spoke with two members of staff the day after the incident and they were aware of the incident.

Safety thermometer

- The service used the NHS patient safety thermometer to support the provision of safe care.
- The scores were all on display on the notice board. In Gladstone 1, for example, there had been three reported falls, but all other indicators scored 0. Records showed that there had been no hospital-acquired pressure ulcers on Gladstone 1 for over two years.
- Nursing key performance indicators (KPI) were tabulated monthly and displayed.

Cleanliness, infection control and hygiene

- All the ward areas were clean and tidy.
- Separate hand washing basins and hand gel were available in all of the wards. We observed staff washing their hands and using antibacterial hand rub in-between contact with patients, and on entering or leaving the bays within the wards.
- Personal protective equipment (PPE) (gloves, aprons, etc.) was available for use by staff in clinical areas. We observed staff wearing PPE when required.
- Staff wore clean uniforms with arms 'bare below the elbow' as required by the trust's policy.

Environment and equipment

- The wards were clean and uncluttered. Audits showed that this was the norm, and patients and staff also confirmed that this was the case.
- There was adequate equipment on the wards to ensure safe care. Equipment was appropriately checked and cleaned, and had been serviced regularly. In Gladstone 1, for example, the equipment in use was visibly clean and dust free, and some had been labelled with the date it had been cleaned. The ward kept a record of the 'weekend cleaning' of equipment. Broken equipment was labelled and reported to the maintenance department for repair.
- The resuscitation trolleys in the wards were checked daily by a designated nurse, and appropriately recorded. Records were seen for the last two months.

Medicines

- In Gladstone 4, we were told that on 21 May 2014 there had been a medication error. This had occurred because a nurse had attached the wrong name label to a patient's medicine chart. This had been discovered two hours later and rectified. The incident was reported on the electronic incident reporting system. The ward manager confirmed that the patient involved was not affected.
- We saw a pharmacist auditing the stock medicines before restocking them. This was done on a daily basis. We were told that a second pharmacist would prepare all the medicines for patients who would be discharged on the day.

Medical care (including older people's care)

Records

- Patients' records had been maintained by staff within the medical department. We looked at 16 patients' care notes and observation charts, and found them detailed and appropriately maintained. In the acute admissions unit (AAU), five patients' medical notes and drug charts were checked, and they were found to be detailed and well completed.
- We observed that standard risk assessments for patients had been undertaken, such as the risk for patients prone to falls, Waterlow scores for pressure areas, and the malnutrition universal screening tool (MUST) score for nutrition. Records showed that these assessments were carried out on admission, and reviewed when the patient's condition changed, or weekly as a minimum.
- All patients' clinical notes in paper format were kept in lockable trolleys within the nurses' station. Confidential information was stored securely, and notices were displayed at nurse's stations to remind staff not to leave patient records on the desk unattended.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients confirmed that their consent had been sought prior to treatment. They described how procedures had been explained to them by both nurses and doctors. We saw patients' signatures of consent in the records we checked. Staff told us that they had always asked patients for their consent before carrying out personal care.
- In Gladstone 1, we saw two 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms, which had been completed and signed by the consultant, and it was documented that relatives had been involved in the decision.
- The ward manager in Gladstone 4 confirmed that there had been no patients subjected to the Deprivation of Liberty Safeguards (DoLS). We found that staff in Gladstone 1 had knowledge of the Mental Capacity Act (MCA), (2005) and the DoLS application process. Staff stated that they would contact senior practitioners if they had any concerns about a patient's welfare. No staff were aware of any applications made under DoLS, or the use of independent mental capacity advocates (IMCA).

Safeguarding

- All the ward staff knew who the safeguarding lead was for the trust. They could articulate what constituted abuse and how to raise concerns.
- We were told that all safeguarding referrals had been completed on time. During the inspection we witnessed a safeguarding referral being made promptly.

Mandatory training

- Staff told us that staff had received mandatory training, including MCA (2005) and DoLS, safeguarding vulnerable adults, infection control, and moving and handling.
- In Gladstone 4, we found staff had received other training on topics such as delirium and dementia, given by the consultant psychiatrist. Staff had also received training on learning disability.
- Junior doctors reported that there was a good teaching timetable and that most of the time they were able to attend the teaching sessions. Medical trainees did not undertake training with other healthcare professionals.

Management of deteriorating patients

- There was an escalation protocol available to ensure that patients received appropriate medical attention. Medical staff were based on the ward during the day, and a site practitioner was available out of hours. Staff told us that they would not hesitate to escalate a concern to the consultant if they needed to.
- The medical service used the national early warning score (NEWS) charts, which gave staff directions for escalation. We case-tracked a patient's care records in Gladstone 4, and observed that the NEWS chart was in use as the patient's condition had deteriorated following admission. There were clear observations and the NEWS recording charts had been appropriately completed. Repeated observations had been made within the necessary timeframe.
- Staff we spoke with had knowledge of the appropriate action to be taken if a patient's NEWS score was elevated. A senior manager confirmed that the NEWS records had been regularly audited.

Nursing staffing

- The head of nursing and the ward manager for Gladstone 1 confirmed that staffing had been reviewed. As a result, the staffing level had been increased so that the needs of patients could be met.
- The ward's quality board listed the numbers of staff on duty, both actual and planned. Staffing was adjusted to

meet the needs of patients. We observed that staff had been brought in to support patients with additional needs; for example, increased observation for a patient who had fallen, or for a patient who was confused.

- We were told that Gladstone 4 had eight vacancies for five staff nurses and three healthcare assistants (HCA). The ward manager told us that the trust had advertised these posts and recruitment was in progress. In the meantime, agency and bank staff had been utilised to make up the numbers. We were told that regular agency staff had been used to ensure continuity of care for patients.
- In Gladstone 4, the ward manager confirmed that the staffing numbers and skill mix were adequate, using agency or bank staff to make up the numbers when required. The ward manager was present on the day of the inspection, to supervise and manage the ward.
- Handovers were carried out in stages. The nurse in charge (NIC) gave a handover in the office. This was followed by a bedside handover that involved the patient. There was also a ward board handover with members of the multidisciplinary team (MDT).

Medical staffing

- Doctors were available 24 hours a day. There was consultant cover seven days a week, including at night. There was appropriate cover by junior and middle grade doctors on the wards, day and night. The medical director visited the wards every morning and was very much involved.
- Consultants were supported by specialist registrars and junior doctors.
- Junior doctors were based on the wards and were readily available to attend to patients when required. They felt that they received good training, had a good relationship with consultants, and were well supported. They had time to attend teaching sessions and had been involved in audits.
- Some junior doctors felt that they had not been getting adequate training in governance and that they were not always given feedback from incidents reported.
- Medical handovers between the night team and the day team took place in the morning, during which a consultant was present.
- Doctor's ward rounds took place daily.

Are medical care services effective?

Good

Care and treatment were provided in accordance with evidence-based national guidelines. Staff ensured that the medical, psychological and personal care needs of patients were met appropriately. This included good pain relief, nutrition and hydration.

There had been formal weekly multidisciplinary team meetings, where patients' conditions and treatment, complaints and concerns had been discussed, and where decisions had been taken to improve patients' care.

Evidence-based care and treatment

- The hospital's protocols were based on the National Institute for Health and Care Excellence (NICE) guidelines. Local policies were written in line with this. Staff knew where to find policies and local guidelines, which were available on the intranet.
- For 2012/13 the trust participated in all but three of the 40 national clinical audits for which it was eligible.
- Central Middlesex Hospital participated in the Myocardial Ischaemia National Audit Project (MINAP). The hospital was rated as within expectations or better than expected in two of the MINAP indicators, and worse than expected in one indicator.
- Central Middlesex Hospital's performance was found to be within expectations for 16 of the 19 indicators in the 2010 falls and bone health audit for older people.

Pain relief

- In Gladstone 4, we observed staff administering medicine to a patient for pain relief. The pain was in the patient's leg, which staff also elevated to allay discomfort. The patient had expressed relief from the pain following this helpful response from the staff.

Nutrition and hydration

- Patients were referred to the dietician to ensure that their nutritional intake was sufficient. Supplementary feeding was arranged as needed, and records showed when naso-gastric or gastrostomy tubes were inserted.
- Patients commented that there was a choice of menu and the food was 'excellent'.
- A relative was pleased that their parent was provided with cultural dishes at meal times.

Medical care (including older people's care)

- We observed jugs of water by each patient's bed. Staff gave patients assistance and encouraged them to drink when appropriate.
- We observed staff checking patients on intravenous infusions, and fluid balance charts had been maintained.

Patient outcomes

- The SSNAP allows comparison of key indicators that contribute to better outcomes for patients. Overall performance was rated from A (highest, which no service achieved) to E.
- It was acknowledged by the audit that very stringent standards were set. Data from October to December 2013 showed that the trust performed well and achieved a grade C overall.
- The trust's performance was rated as within expectations or better than expected for four of the MINAP indicators.
- In the National Diabetes Inpatient Audit 2013 the trust were worst that the national average for the number of hours a week that the specialist team providing care. This included nurse, consultant, dietician, podiatrist and pharmacist hours which were all below the national average. Whilst emergency admission rates are higher than the national average the actual number of patients admitted for diabetes as the primary reason is small and below average.
- The clinical site practitioner confirmed that there had been very few patient readmissions within 28 days as per the target set.

Competent staff

- Team leaders carried out the appraisals for nursing staff, identified training and development needs, and maintained records of staff training. The e-rostering system issued alerts when mandatory training was due. Ward meetings and handovers were used to discuss issues and concerns.
- Staff reported that they had attended induction on starting employment, and had attended mandatory training. They reported that they were supported to gain new skills and had opportunities to attend courses when they were advertised.
- In Gladstone 4, we were told that the majority of the nurses had received training on cannulation and phlebotomy. There were mentoring arrangements for newly appointed junior nurses.

Multidisciplinary working

- There was evidence of multidisciplinary working within the department, with other services within the trust, and with external organisations. For example, two consultants who specialised in neuro-rehabilitation have wards in local community hospitals.
- There were good shared-care arrangements with surgeons from Northwick Park Hospital. For example, Gladstone 4 received orthopaedic patients requiring rehabilitation from Northwick Park Hospital.
- Sometimes patients were placed in an inappropriate ward because of the shortage of beds. When this happened, doctors said that they sometimes had difficulty in contacting the staff team on the other ward.
- The bed manager confirmed that there were daily video-linked bed management meetings held with Northwick Park Hospital to facilitate patient transfers.
- In Gladstone 4, there was a multidisciplinary team (MDT) meeting every Tuesday, which involved the consultant and their deputy, the occupational therapist, the physiotherapist and the discharge co-ordinator.
- There were daily and weekly ward rounds carried out by the MDT.

Seven-day services

- There was 24 hour cover, with one registrar supported by three junior doctors. Other registrars were on-call after 5pm. On-call out-of-hours cover was provided by consultants after their last ward round. There was an anaesthetist on site 24 hours a day.

Are medical care services caring?

Good

Patients, and those close to them, were complimentary about the way that staff cared for them, and they felt respected by staff. Patients felt involved in decision-making about the care, support and treatment that they received.

Psychological support included a referral to a specialist psychiatrist if required. Clinical nurse specialists were available in various disciplines, such as end of life care and dementia.

Compassionate care

- The Friends and Family Test result indicated that people would recommend the hospital.

Medical care (including older people's care)

- The wards in Gladstone 1 and 4 were divided into four, four-bedded bays with eight en suite single rooms. There had been no breaches of the same sex accommodation policy, and there were designated gender-specific bathroom facilities.
- Staff respected patients' privacy by closing the curtains around their beds when appropriate, and they were observed to ask each patient for permission to enter. Call buzzers were answered promptly. Patients reported that staff were always available when needed, and that they did not have to wait long for buzzers to be answered.
- Patients were complimentary about the staff from every discipline. Comments received included, "Staff are very good; when I need them, I use the buzzer and they come in straight away" and "staff are polite and helpful".
- We observed that staff had warm, professional and caring conversations with patients, who were overheard laughing and joking with staff.

Patient understanding and involvement

- Patients felt that they had been involved in their care and treatment. They felt well informed before they signed the consent form for treatment. Comments received included, "they are doing their best", "both doctors and nurses keep us informed" and "the doctor explained things to us". However, there was one patient who felt that the doctor had not discussed their care with them.
- There was a good range of information leaflets available, and they had been updated regularly.
- Patients were allocated a named nurse for each shift. The name of the consultant was displayed on a bedside board. We noted that patients knew the names of the staff.

Emotional support

- We were told that in the case of long-term patients who required emotional support, the medical team had made referrals to the specialist psychiatrist from a nearby hospital.
- In Gladstone 4, relatives of one patient were supported by staff when they expressed concern about their parent's potential discharge to their own home. Action taken by the staff had allayed their anxiety, and placement to a nursing home had since been arranged with all parties involved, including social services.

Are medical care services responsive?

Good

People were able to access medical services in a way that was convenient for them. However delays were experienced by patient's treatment when a surgical consultation was required. The staff had received appropriate training to meet the needs of the community, including equality and diversity, and dementia training.

The service maintained good communication and relationships with local GPs and other healthcare providers. This had ensured that patients received continuity of care when discharged from the hospital.

Service planning and delivery to meet the needs of local people

- The coronary care unit (CCU) was designed so that it could be used as a chest pain assessment unit. It was also used as a step down facility from Northwick Park Hospital.
- The process for moving patients to and from Northwick Park Hospital worked very well.

Access and flow

- There was a good flow of patients through the hospital, whether day case or inpatient, through to discharge. However due to the lack of surgeons within the hospital when there was a cross referral delays could be experienced by patients.
- In Gladstone 1, outliers were accommodated on the ward. Staff worked with the site practitioners to ensure that patients were placed on appropriate wards.
- When a patient was discharged, a discharge summary was sent automatically to the GP by email. This detailed the reason for admission, the results of any investigations, and the treatment that the patient received.
- There was a discharge lounge available where patients could wait for transport, and this freed up beds for new admissions. The discharge lounge was open from 9am to 6pm, and was staffed by a nurse. There were facilities available to provide drinks and snacks. A register was kept of patients brought to the lounge.
- The discharge co-ordinator reported that they monitored delayed discharges. We were told that there were approximately 30 per week.

Medical care (including older people's care)

Meeting people's individual needs

- Staff had received appropriate training to meet the needs of the community, including equality and diversity, and dementia training. As a result, they were able to care for people with dementia. They could seek advice from the dementia lead, and could access e-learning. Literature was on display to inform staff of types of dementia, and how they should care for people with dementia.
- Staff employed were from multi-ethnic backgrounds, which reflected the local population.
- Translation services were available for patients when appropriate, via a contracted provider.
- Discharge co-ordinators were allocated to the wards to assist with complex discharges. Families and carers met with the multidisciplinary team (MDT) to discuss discharge arrangements.
- The ward manager was involved in arranging 'normal' discharges, and ensured that appropriate referral forms were completed and sent to the local authority. We saw the discharge care planning documentation being completed by staff and arrangements confirmed.
- The ward manager and the matron did ward rounds to pick up any issues from patients. Many 'thank you' cards were on display, and the staff kept a record of those received.
- Staff supported patients with physical, mental health and cultural needs.
- In Gladstone 4, we observed that cultural-specific food and drinks were provided by the ward for patients. We noted that the English interpretation of a foreign language was on the wall by the bed of a patient in order to aid staff in communicating with them.
- The psychiatric liaison nurse from another trust would review a patient if referred by a doctor.

Learning from complaints and concerns

- Staff confirmed that the ward manager had discussed at staff meetings any concerns or complaints raised and the lessons learned.
- Issues discussed at MTD meetings that were attended by managers were fed back to staff at local staff meetings.
- There was information displayed on the wards about how to provide feedback on the service patients had received, and how patients and relatives could make a complaint.

Are medical care services well-led?

Good

The medical service had clear line management arrangements. Staff were well supported by the trust's medical director, who visited Central Middlesex Hospital on a daily basis.

The consultant-led team of medical staff held clinical, audit, mortality and morbidity meetings. Senior clinicians were visible and approachable, and staff told us that they listened to them.

Systems were in place for clinical governance. There was a risk register for the directorate, and risk management issues were discussed at directorate meetings, held every two weeks.

Vision and strategy for this service

- Staff were aware of the names of the chief executive and the medical director, both of whom were very well respected. There were pictorial board structure posters displayed throughout the hospital, but staff were unable to recall the names of other board members.
- Staff told us that the chief executive had held open forum meetings to update them on the proposed closure of the A&E department, and the trust merger with Ealing Hospital NHS Trust.
- Staff had been sent daily emails and the chief executive's bulletin to update them on trust developments. Some staff reported that they did not always read those updates.

Governance, risk management and quality measurement

- The consultant-led medical staff team held clinical, audit, mortality and morbidity meetings.
- Risks were identified and escalated to middle managers. Ward managers did not maintain a risk register for their area of responsibility. There was a directorate risk register with each risk red, amber, green (RAG) rated. This was discussed at directorate meetings, which were held every two weeks.
- Systems were in place for clinical governance. Incidents were reported through an electronic incident reporting system. However, they were not always marked as

'closed' on the system when they had been dealt with. A new clinical governance manager had started work recently in order to ensure more robust monitoring of risk.

- The quality board showed that there had been a 50% reduction in ward team sickness rates. The head of nursing reported that 32 staff members had been performance-managed at Central Middlesex Hospital. The ward manager made calls to staff on sick leave to enquire about their welfare, and to remind them to submit their sickness certificates.

Leadership of service

- There were clear line management arrangements. Staff knew the matron, head of nursing and the general managers of the directorate. They told us that the matron and head of department were very visible on the units, and that they could approach them about anything.

Culture within the service

- Staff reported they did not know very much about the staff survey, and no one was aware of bullying and harassment issues. Staff were unanimous in saying that they would report such incidents. Staff expressed great confidence that the senior management of the directorate would address any concerns highlighted.
- Staff told us that the medical director visited the hospital daily, and that senior clinicians were visible and approachable.
- Staff were uncertain about the future of their service following the closure of the A&E department in September 2014.
- Consultants at Central Middlesex Hospital felt disconnected from the Northwick Park Hospital site.

Public and staff engagement

- Patients, and those close to them, gave positive feedback about the care and treatment that they received.

Innovation, improvement and sustainability

- Doctors had raised an issue with the consultants concerning the inappropriate handover of patients on Friday afternoons. As a result, improvements had been made, and a screening process was now in place to ensure that all jobs were handed over appropriately to ensure patient safety.

Surgery

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

Information about the service

Central Middlesex Hospital undertakes elective surgery only, including day cases. They are based around Abbey Ward, which also includes care for specialist orthopaedic patients and has a total of 24 beds.

Summary of findings

Surgical services provided safe and effective care in the areas we visited. There were appropriate numbers of nursing and medical staff, and staff followed guidance when providing care and treatment.

Staff were caring and supportive of patients, and made efforts to keep them involved in decisions about their care and treatment.

Arrangements were in place to accommodate the different religious and cultural needs of patients. There was usually a suitable flow of patients through the department. However, there were isolated issues relating to inadequate pre-assessments prior to patients being admitted to the department.

There were suitable arrangements in place to monitor the quality and safety of the service.

Surgery

Are surgery services safe?

Good

Surgical services provided safe care to its patients. There were appropriate numbers of nursing and medical staff. Policies and procedures were in place to ensure that patients were kept safe whilst on the ward and undergoing surgery. Staff undertook checks to make sure that these procedures were adhered to.

Incidents

- Between December 2012 and January 2014 four 'never events' took place at the trust. This was considered to be within the acceptable range. All four of these related to surgical services.
- Staff were able to describe the changes that had been made to the way they worked as a result of the review of incidents. We saw records of multidisciplinary committee meetings where incidents were discussed, including causes and how they would be prevented in the future.
- In addition, the department reported 35 incidents to the National Reporting and Learning System (NRLS). Of these, 24 were classified as 'moderate', three as 'abuse', four as 'severe' and four were deaths.
- Staff were aware of how to escalate incidents within their own wards using the electronic incident reporting system.
- Morbidity and mortality meetings took place on a monthly basis.

Safety thermometer

- The department used a safety thermometer to monitor the safety of the services it was providing. The performance of the department between April 2013 and March 2014 was rated positively, at 98.35% harm-free. Results were collected for each ward, so that isolated episodes of poor performance could be highlighted.

Cleanliness, infection control and hygiene

- During our inspection all areas that we saw were clean and tidy. Hand washing facilities, sinks and personal protective equipment were available throughout.

Environment and equipment

- Appropriate emergency drugs and equipment were available throughout the department. Regular checks were made on these to ensure that they were in date, and in good working order.

Medicines

- All medicines were stored in a secure manner that was accessible only to staff. Records were kept of what medicines had been administered.

Records

- We reviewed patient records across the department, and they showed that basic information and risks assessments were appropriately completed. Patient observations were up to date. Details of daily multidisciplinary team (MDT) meetings were included, as was discharge data.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received mandatory training in consent, the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.
- There were specific forms to be completed when a person was unable to consent to surgery that indicated the reasons that this was the case.
- In the records we reviewed, patients' consent to surgery was appropriately completed.

Safeguarding

- There was a safeguarding policy and procedure in place.
- Staff received mandatory training in safeguarding vulnerable adults, though take-up of this training was variable across the department.
- There was an internal trust safeguarding team to whom staff could report concerns.

Mandatory training

- The trust kept a record of mandatory training completed by staff within the surgical department. Whilst a satisfactory range of topics were covered, including basic life support and infection control, the information provided showed variable rates of completion of this training across the department.
- It was noted that whilst some staff had received basic life support training, not all staff had been trained to use the defibrillators on the resuscitation trolleys.

Surgery

Management of deteriorating patients

- The World Health Organization Surgical Safety Checklist was used by the department to ensure that patients were safe prior, during and after surgery. Recent audits of the completion of this did not highlight any risks within the department.
- The department used an early warning scores system to monitor the ongoing condition of patients. In recent audits most wards scored highly in terms of their use of this tool.

Nursing staffing

- Senior staff reported that they used the 'Hurst' workforce planning tool, as well as a recently commissioned report by an external company, to decide on the nursing levels and skills mix of nursing staff that they needed on each ward.

Medical staffing

- Some staff reported that surgical doctors mainly attended promptly when requested, although others said that it could be difficult to get hold of them on some occasions.

Major incident awareness and training

- There was a major incident policy and procedure in place.
- Staff had training in what to do in the event of a major incident.

Are surgery services effective?

Good

Staff followed appropriate guidance when providing care and treatment. They were suitably trained for their roles, and worked well with other professionals and departments. Senior staff were available throughout, and audits were undertaken to monitor the quality of outcomes for patients. However, patients were not always assessed appropriately at Northwick Park Hospital, which led to delays in care being provided.

Evidence-based care and treatment

- There was a team of consultants who sent out bulletins each month on any new National Institute for Health and Care Excellence (NICE) guidelines that had been published. In addition, specialist nurses (such as Tissue Viability Nurses) provided specific guidance to staff on any development in their fields. New developments were discussed at handovers.
- Standard risks assessments were used to evaluate patients, and ensure that they were safe whilst within the department. These included the Waterlow assessment to check for risks of pressure ulcers, and the MUST nutritional screening tool. There were also specific assessments, undertaken to ensure that patients were fit and well enough to undergo surgery, which followed national guidelines.

Pain relief

- There were specific policies on pain relief within the trust. Staff reported that post-operative pain was discussed with patients during the pre-operative stage.
- Prescribing nurses had specific assessment tools and guidance they could use to provide pain relief to patients in the absence of medical staff.
- Comprehensive patient group directions (PGD) were available to nursing staff, about pain relief and medicines they could provide to patients. These were reviewed on a regular basis.

Nutrition and hydration

- Patient records we reviewed at the hospital showed that nutritional assessments and fluid balance charts had been completed correctly.

Patient outcomes

- Staff told us that some patients they received, who had been pre-assessed at Northwick Park Hospital, had not undergone an appropriate assessment and were admitted with additional medical conditions that had not been identified during the assessment. This resulted in their surgery having to be delayed whilst they underwent appropriate pre-operative assessment, preparation and treatment on the main ward.

Competent staff

- The trust was actively recruiting nursing staff from overseas in order to fill vacancies. Once recruited, they were given time to adjust to the NHS, and there was a specific induction course for them to complete.
- Nursing staff had access to mentorship programmes. They had annual appraisals with six monthly reviews. They had supervision, where senior staff assessed their clinical work and provided feedback to them.

Surgery

- Staff reported that the use of medical locums at the weekend could be problematic, as not all of them had access to the computer system, and so needed another doctor to be present when they used it.
- There were concerns that the volume of work for specialist registrars would hamper their ability to deliver training to more junior doctors.

Multidisciplinary working

- Multidisciplinary team working was evident. Allied healthcare professionals, such as physiotherapists and radiological staff, were available on request. However, some staff across the department reported delays in getting radiological assistance in some cases (such as for ultrasounds).

Are surgery services caring?

Good

We observed positive interactions between patients and staff. Staff were caring and supportive of patients, and made efforts to keep them involved in decisions about their care and treatment. However, some patients expressed concerns that medical staff did not explain things to them in as much detail as they would have liked.

Compassionate care

- We spoke with ten people using the service across the hospital. They told us that they were happy with their treatment, and the way that they had been looked after. Nurses were described as "caring" and "helpful".
- We observed numerous examples of patients being treated with care and consideration. Their privacy and dignity was respected, with curtains being drawn around their beds when appropriate.
- In the Friends and Family Test undertaken in February 2014, none of the surgical wards scored lower that the trust average for patients who would recommend the service.

Patient understanding and involvement

- Staff provided written information to patients pre-operatively on how to prepare for procedures.
- One patient told us that they had been provided with an explanation of their condition and treatment by staff.
- The main ward ran workshops for future orthopaedic patients that covered what their treatment and recovery would involve.
- Some patients said that their time with medical staff had been brief, and they did not feel that they had received full explanations of their condition/treatment. In addition, staff noted that the main issue raised in complaints across the trust was usually a lack of, or poor communication with, patients.
- All nursing staff that we observed wore name badges.

Emotional support

- Staff had access to the bereavement services within the trust, as well as different religious persons, should patients/relatives/carers require such support.

Are surgery services responsive?

Good

Surgical services were responsive to people's needs. There were plans in place to deal with increases in the volume of patients being seen at Central Middlesex Hospital. Arrangements were in place to accommodate the different religious and cultural needs of patients. There was usually a suitable flow of patients through the department. However, there were isolated issues relating to inadequate pre-assessments prior to patients being admitted to the department. This meant that on some occasions, it would be over 24 hours between patients' admission and their procedure, resulting in blockages to the system.

Service planning and delivery to meet the needs of local people

- The department operated a winter plan to increase their resources across the winter months to account for the greater volume of patients.

Access and flow

- Inadequate pre-admission assessment at Northwick Park Hospital resulted in patients being admitted to the main ward at Central Middlesex Hospital for extended periods prior to their procedure to undergo appropriate assessment, pre-operative treatment and preparation.
- Staff reported that on some occasions, beds were removed by the trust, which made appropriate admission planning difficult.

- Discharge planning started pre-admission or on admission, and involved numerous professionals, including occupational health and social services where appropriate. Discharge plans were monitored as part of the daily handover.
- There was a specific risk assessment to be completed before patients were discharged. This looked at what the needs of the patient were, the plans needed to be made, and the resources to be put in place before they were discharged.

Meeting people's individual needs

- There were a range of food options to meet people's cultural or religious needs.
- Translation services were available if people need them, but staff would also utilise their colleagues who could speak different languages.
- Staff received training in caring for and treating people with dementia.

Learning from complaints and concerns

- There was a process in place for the receipt, investigation and feedback on complaints.
- Staff reported that they received complaints, as well as positive patient feedback.

Are surgery services well-led?

Good

Local leadership was good, as staff described a supportive team environment. There were suitable arrangements in place to monitor the quality and safety of the service. However, while staff were aware of the performance of the department, they were unclear as to when the trust would take action to address any issues. There were widespread concerns about the future of the department and support services, given the developments within the hospital as a whole.

Vision and strategy for this service

- Whilst staff had an idea of the performance of the department, where improvements were needed, and the general plans for making them, staff were not clear on how or when these improvements would be made.
- A large proportion of staff were concerned about the future of the hospital in general, as well as the safe functioning of the department with the ongoing loss of services from the hospital.

Governance, risk management and quality measurement

- The department collected suitable information on both the safety of the service, and the quality of outcomes of treatment.
- There were regular meetings of senior staff, both nursing and medical, where performance was discussed and plans made to address any issues.

Leadership of service

- Senior staff spoke positively about the current senior management within the trust, and said that they retained the confidence of senior medical staff.

Culture within the service

- Staff that we spoke with, at all levels, described friendly and supportive relationships within the surgical services team. However, numerous staff remarked on the pressure that they and their colleagues were under.

Public and staff engagement

- The department used the Friends and Family Test in order to obtain feedback from patients and relatives. However, aside from this and the spontaneous feedback provided by patients and their families, the department did not employ a method to obtain systematic in-depth feedback on the quality of the service they were providing.

Critical care

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

Information about the service

Critical care at Central Middlesex Hospital is comprised of a four bed intensive treatment unit (ITU) and a four bed high dependency unit (HDU). Both planned admissions from the surgical and medical teams, as well as emergency admissions from the A&E department, are admitted to the units.

Summary of findings

The critical care services at Central Middlesex Hospital require improvement. There were appropriate numbers of suitably-trained staff, who worked according to procedures to keep people safe. Staff collected ongoing data on the safety and performance of the department, which indicated positive patient outcomes.

Staff were caring towards patients, and were able to respond to fluctuations in demand. However, governance arrangements could be improved, as could the strategy and vision for the department as a whole. Whilst morale within the team was positive, it was not clear how the unit linked with the trust-wide department as a whole.

Critical care

Are critical care services safe?

Good

Staff actively monitored the safety of the service and responded to any incidents or low performance figures. The environment was appropriate for the care and treatment carried out, and there were appropriate numbers of suitably-qualified staff.

Incidents

- Between December 2012 and January 2014 five serious incidents took place in intensive care / high dependency units within the trust as a whole, and these were reported to the Strategic Executive Information System (STEIS). Between February 2013 and March 2014 four incidents were reported to the National Reporting and Learning System (NRLS), all of which were given a rating of 'moderate' severity.
- There was a procedure in place for incidents to be reviewed and learning taken from them. Appropriate staff were kept up to date with the outcomes, and any relevant changes to practices or procedures.
- Staff reported that mortality and morbidity meetings did not take place on a regular basis. We were told that deaths were discussed at weekly multidisciplinary meetings. However, these did not constitute an in-depth review of the circumstances of the death, and if any learning could be taken from them.

Safety thermometer

- Staff monitored the safety of the department using a 'safety thermometer', whereby the number of falls and pressure ulcers (amongst other indicators) where monitored. At the time of the inspection, no significant safety issues were highlighted by this tool. The results were displayed within the critical care unit.
- In addition, staff reported on data that was collected from numerous other sources to assess the safety of the service. This included data from patient notes and their daily records. These results were analysed, and staff told us of specific improvements that had been driven by this process, for example, improvements in the mortality rate and the number of days that patients were on ventilators.

Cleanliness, infection control and hygiene

- Staff reported that infection control audits took place on a regular basis and we saw evidence of this. This included monitoring the number of healthcare-associated infections of patients, as well as compliance with hand washing protocols and the general cleanliness of the department's environment. We reviewed this data and noted that no significant issues were raised with the cleanliness of the environment.
- Clinical areas we visited were clean and tidy. We observed staff adhering to infection control policies and procedures, such as the use of personal protective equipment and hand washing.
- However, the infection control policy was not readily accessible to all staff.

Environment and equipment

- Emergency equipment and drugs for resuscitation were available throughout the department, and there were checks on these to ensure that they were in good working order and in date.

Medicines

- Medicines were securely stored and were accessible only to authorised staff.

Records

- We reviewed a selection of patient records. All had appropriate risk assessments completed, such as nutritional and pressure ulcer risk assessments.
- Clinical observations and medication administration records were complete and up to date.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff undertook mandatory training in consent, the Mental Capacity Act and Deprivation of Liberty Safeguards.

Safeguarding

- Staff undertook mandatory training in safeguarding vulnerable adults. There were guidelines and protocols about how staff should act on any concerns identified within the critical care unit.

Mandatory training

- Staff undertook mandatory and refresher training on a regular basis, in appropriate topics including basic life support and infection control.

Critical care

- Most staff were up to date with their mandatory training. The management was aware of the staff members whose training was out of date and overdue for an update.

Management of deteriorating patients

- The department used the national early warning scores (NEWS) system to alert them to when a patient's condition may be deteriorating.
- There was a specific policy in place covering the management of deteriorating patients, which included details around observation and monitoring, as well as clinical responses. This was written in March 2013 and had been scheduled for review in March 2014.

Nursing staffing

- Nursing levels were based upon the Royal College of Nursing and the British Association of Critical Care Nurses guidelines.
- There was a high proportion of senior grade nurses (65% at band six or seven), with 35% at band five.
- We looked at previous rotas which confirmed that the planned nursing staff levels were maintained over time.
- The nursing staff that we spoke with said that they were well supported on the unit.

Medical staffing

- There were appropriate numbers and grades of medical staff for the number and acuity of patients on the units. We looked at previous rotas and noted that these numbers and mix had been sustained over time.
- However, it was noted that on some days, there were no trainees present, and the department was reliant on the use of locums on other days.
- The units were covered by the anaesthetic resident out of hours.
- An outreach team operated throughout the hospital 24 hours a day, five days a week, and 12 hours per day at weekends.
- There was difficulty obtaining a surgical consultation.
- There was a lack of imaging services at the weekends.

Major incident awareness and training

- There was a major incident policy and procedure in place.
- Staff had training in what to do in the event of a major incident.

Are critical care services effective?

Requires improvement

The unit, whilst undertaking some local audits, such as the NW London audit, were unable to identify through standardised audit areas for improvement and performance management. There were some mechanisms and audits to monitor the quality of treatment outcomes. Staff worked well with each other and other departments within the hospital. There was appropriate guidance for nursing staff, although very little was available for medical staff, and this was an issue across the trust.

Evidence-based care and treatment

- Staff used the national early warning scores (NEWS) system to monitor the condition of patients. They used industry-standard risk assessments, such as the Waterlow pressure ulcer tool and the MUST (Malnutrition Universal Screening Tool).
- There were trust-wide policies available on the intranet, which provided general guidelines on providing nursing care, and these were mainly up to date. However, there were very few protocols for medical staff. For instance, there were no protocols on important aspects of critical care such as sedation, management of septic patients, or renal replacement therapy. This posed a risk of inconsistent or inappropriate care and treatment of patients. In addition, because these protocols were not in place, senior staff were very limited in what treatment they could delegate to junior medical staff to carry out, and had to treat patients themselves.
- Nursing and medical staff undertook audit work looking at the outcomes of care and treatment for patients using the NW London audit tool. The information gathered did not indicate any significant issues. However, it was noted that a large proportion of this information was gathered using a local tool, and was not benchmarked against national data such as the ICNARC programme. At the time of the inspection, information was not available about how the trust rated against the other local trusts that used this tool.

Pain relief

- There were written protocols for nursing staff on the provision of analgesia for the alleviation of patients' pain.

Critical care

Nutrition and hydration

- We reviewed the records of six patients across the trust. Nutrition and hydration risk assessments had been completed were appropriate. Fluid balance charts were recorded on a daily basis and there were daily nursing evaluations of nutrition and hydration. Records showed that a dietician was involved when appropriate.

Patient outcomes

- Recent audits of the performance of the department between March 2013 and January 2014 showed that patient outcomes were positive in most areas, including late night discharges, readmissions within 48 hours, and length of stay.

Competent staff

- Nursing staff begin working in the department as supernumerary for the first month, so that they could learn about the department. Staff were supervised on a regular basis.
- The nursing staff members that we spoke with said that they felt well-supported.
- Medical locums were used extensively throughout the department. Not all locums had access to the computer system, so they were reliant on other medical staff being present for some of their duties.

Multidisciplinary working

- Multidisciplinary team (MDT) meetings took place on a weekly basis. These would feature consultants, ITU trainees, the microbiologist and nursing staff, as well as other relevant healthcare professionals. Staff reported that they would also try and link to the Wednesday MDT at Northwick Park Hospital.

Are critical care services caring?

Good

We observed positive interactions between patients and staff. Patients were treated in a caring manner and involved in decisions about their care and treatment when possible.

Compassionate care

- Throughout the inspection we saw patients and their families being treated in a kind and considerate manner by staff members.
- Three patients told us that they were very satisfied with the quality of care that they received at the critical care facilities at Central Middlesex Hospital.
- Patient's dignity and privacy was respected throughout, with curtains being drawn around cubicles when personal care and treatment was being provided.

Patient understanding and involvement

- There were written records of family members being involved in the planning of, and decisions about, patients' care and treatment.
- In one record we reviewed, staff had documented the discussion they had had with a patient's family about resuscitation.
- We observed a ward round where staff discussed care and treatment plans with patients.

Emotional support

- Staff had access to the trust's bereavement services, as well as a range of religious persons.

Are critical care services responsive?

Good

Access to the department and flow through it were positive. People's individual needs were met, and the critical care units at Central Middlesex Hospital could help to meet the increased demand for beds at Northwick Park Hospital.

Service planning and delivery to meet the needs of local people

- There was a policy and procedure in place for the units to accept transfers from other local facilities, in particular Northwick Park Hospital, and this occurred on a regular basis.

Access and flow

- Audit information relating to this hospital showed that the critical care units were scoring well in terms of patients' length of stay, a lack of night discharges, and a lack of re-admissions within 48 hours. These factors indicated a positive patient flow through the department.

Meeting people's individual needs

- The service had access to translators if needed, and these were advertised on the units.

Critical care

- Following their discharge, all patients who had stayed in critical care for three days or more, were invited to attend up to three follow-up outpatient appointments, to check on their progress.

Learning from complaints and concerns

- There was a policy and procedure in place for the recording, investigation and responding to of complaints.

Are critical care services well-led?

Requires improvement

There was a lack of vision or strategy for the entire team, and leadership from the overall trust was lacking. There had been no clinical lead for the service which impacted on the direction for the service. Medical staff complained of the lack of supervision. There were arrangements in place to manage the day-to-day operation of the units, and to make sure that patients were safe. Morale and leadership within the team was positive. All staff were concerned for the future of the hospital as a whole.

Vision and strategy for this service

- There was no overall strategy or vision in place for critical care services. It was noted that there had been no clinical lead since March 2014, the lead at Northwick Park Hospital had been covering, but staff reported that one had been appointed in the week prior to our inspection.

Governance, risk management and quality measurement

- There were systems in place for governance, risk management and quality measurement within the department. There were specific data items that needed to be collected by staff relating to nursing and medical care, as well as other measurements. These were reviewed on a systematic basis and feedback was provided to staff. However, it was not clear whether this information was always benchmarked against other local or national providers.

Leadership of service

- Nursing staff within the department described a positive environment to work in. They said that they felt well supported and that senior staff were visible.
- Medical staff described their leadership as poor. We noted that the member of staff who was responsible for monitoring the performance of the department had recently stood down from this role; the lead at Northwick Park Hospital was now covering both sites.

Culture within the service

- All staff that we spoke with expressed concerns about the future of the hospital, as well as the continued functioning of the department with reduced services available on site.

Public and staff engagement

- Whilst the trust received the results of their Friends and Family Test, showing that people could make complaints or comments, no further efforts were made to engage with members of the public.
- Whilst staff had raised concerns to senior directors, it was noted that the lack of a clinical lead could be contributing to the delays in changes taking place.

Innovation, improvement and sustainability

- It was noted that pressure on staff workloads may mean that there was limited time for them to reflect on practice or undertake research.

Services for children and young people

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

Information about the service

Central Middlesex Hospital paediatric service is made up of a day surgery provision and an outpatients facility. The day surgery service operates Monday to Friday. This is managed by the critical care matron. We talked to three patients and six relatives, and eight staff, including consultants, doctors, nurses and healthcare assistants. We observed care, and we reviewed other documentation, including performance information provided by the trust. We received comments from our listening event, and from people who contacted us to tell us about their experiences.

The outpatients unit is known as the Rainbow Children's Centre and is managed by staff at Northwick Park Hospital. The Rainbow unit offers children's outpatient services three and a half days a week, and has specialist diabetes and epilepsy services. There is a dedicated paediatric haemoglobinopathy service for children and young people with sickle cell disease.

Summary of findings

The day surgery unit and the Rainbow Children's Centre at this site were differently managed. The day surgery unit was managed by staff at Central Middlesex hospital whilst the rainbow Children's Centre was staffed by staff from Northwick Park Hospital. We found huge variances between the two services and have listed them separately. The day surgery unit offered good information for families and children before procedures, had good processes and protocols, and families were pleased with the service.

By contrast, the outpatient clinics run at the Rainbow Children's Centre gave us cause for concern because there was no registered children's nurse and there were some poor practices around medicines management. The clinics were not child-friendly and lacked play facilities.

Services for children and young people

Are services for children and young people safe?

Requires improvement

The day surgery unit environment was clean and well maintained, with good standards of hygiene and clean items identified as clinically clean. Systems, processes and practices in this unit worked smoothly.

However, we had some concerns about the environment of the outpatient clinics which did not make suitable provision for children. There were no toys to occupy children while waiting for appointments, and consultation and diagnostic rooms were stark and clinical. The clinics did not have a registered children's nurse, and in the event of a medical emergency, would have to rely on the A&E department in the hospital. We observed a cluttered and untidy treatment room being used for monitoring blood pressure, which did not meet appropriate standards of hygiene and safety. We also found that levels of training varied and some were not appropriate for the service the hospital delivers.

Incidents

- Neither the day surgery unit nor the Rainbow Children's Centre had reported any serious incidents in the last two years.
- There had been no 'never events' (events that are largely preventable if the right actions are taken), in the last two years.
- Staff told us that any incidents were recorded and investigated.

Cleanliness, infection control and hygiene

Day surgery

- The environment was clean and well maintained.
- There was sufficient personal protective equipment.
- We observed staff washing their hands and using hand sanitizing gel, and all were practicing the 'bare below the elbows' policy.

Outpatients

- Hand washing facilities were adequate.
- Personal protective equipment was available.
- The waiting area and clinic rooms were clean.
- However, we did observe that there were blood splashes on the box for disposal of sharp items.

Environment and equipment

Day surgery

- This unit was well designed, clean and well equipped.
- Green labels were used and dated to denote that items had been cleaned.
- The operating theatre had specialist equipment available for paediatrics. There was a designated paediatric recovery area and equipment.

Outpatients

- Some of the clinics attended by children at Central Middlesex Hospital, such as audiology, were adult clinics and not child-friendly.
- There was no registered children's nurse associated with these clinics.
- There was no evidence of environmental risk assessments being carried out.
- The shared waiting area for ear, nose and throat (ENT) and audiology was small, and there were no toys. The play facilities had been removed after a child had tripped on a toy.
- The audiology and ENT clinics were well equipped to deliver care and treatment to children.
- One treatment room with a security keypad was propped open rather than locked, and the room was untidy. The resuscitation trolley in that room had not been checked regularly and contained a number of out-of-date items, some from 2012, and no paediatric resuscitation guidelines were available. There was an out-of-date oxygen cylinder.
- Data-scope monitors were overdue for servicing, and the lock for the room they were in did not work. There was a sign saying that the room was to be locked at all times.
- Patient trolleys used in outpatients were covered with paper, and new paper was used each day, but there was no cleaning schedule for the trolleys.
- All the above safety concerns were reported to the estates and pharmacy departments, and were rectified on the day of the inspection.

Medicines

- We had no concerns about medicines in the day surgery unit.

Services for children and young people

- However, we observed poor medicine management in the outpatients department. The drug fridge was iced up, contained an out-of-date Mantoux test vial, and was not locked. Staff stored milk in the drug fridge.

Records

- There was sufficient information recorded in children's notes, including medical history, needs for daily living, and consent, if needed, for surgical procedures.
- In the outpatients unit, we were told that notes were not always available for clinics.

Consent

- Parental consent was recorded in all the children's notes in the day surgery unit. Parents said they had sufficient information to give consent to treatment.
- Most day surgery was on younger children, but we were told that when necessary, older children were involved in discussions and gave their own consent, if assessed as competent to do so.

Safeguarding

- Staff could describe the referral process for alleged or suspected child abuse, and knew the names of the lead professionals. They were confident that the system for identifying abuse was robust and had dealt with safeguarding cases.
- The safeguarding team were based at Northwick Park Hospital. A paediatrician was the named doctor, and a nurse, the named nurse, for safeguarding.
- Only 20% of paediatric staff at the outpatient clinics had attended level 3 safeguarding training.

Mandatory training

- Only 26.8% of staff were up to date with mandatory training in the outpatient clinics.
- There was no information on how many staff had had performance appraisals in the past year.
- No disaggregated information was available on training and appraisals in the day surgery unit.

Assessing and responding to patient risk

- Children were pre-assessed before surgery, either face-to-face, or by telephone. Children with learning difficulties attending pre-assessment were assessed as soon as possible, and often in a side room, to minimise their waiting time.
- No children under two years of age had day surgery.
- Staff told us that after assessment, surgery usually occurred within eight weeks. One child we spoke with had waited only two weeks.
- Parents told us that clear and reassuring information had been given to them about surgical procedures.
- The Paediatric Early Warning System (PEWS) was used to identify children who were becoming more unwell. We saw that observations were carried out and recorded in the day surgery unit.
- The training for nurses and healthcare assistants included PEWS and the recognition of the sick child.

Nursing staffing

Day surgery

- There were sufficient staff, with the right range of skills.

Outpatients

- The outpatient clinics were run by a healthcare assistant (HCA) who worked for the rest of the week at Northwick Park Hospital. No nursing staff were employed by the clinics. The HCA told us that they would report to the children's ward manager at Northwick Park Hospital if there were any concerns.
- There was an A&E department at the hospital, and therefore emergency medical support was available if needed. However, the A&E department was due to close in autumn 2014. We noted that the withdrawal of this safety mechanism was not on the risk register.

Medical staffing

- There were sufficient medical staff for the paediatric service.

Are services for children and young people effective?

Good

The day surgery unit worked smoothly, and we were told there were relatively few cancellations. Almost all children were able to return home after their surgery. If their admission needed to be extended, they would be transferred to the ward at Northwick Park Hospital.

The outpatient clinics used national guidelines in most cases. The exception was for treating children with epilepsy.

Services for children and young people

Evidence-based care and treatment

- Evidence-based guidance from the National Institute for Health and Care Excellence (NICE) was used in most areas.
- Epilepsy management did not follow NICE guidelines, as there was no nursing support provided. Paediatricians had discussed this in a recent meeting with the North Thames Epilepsy Network.
- The trust was taking part in a regional epilepsy audit linked to Ealing Hospital.

Pain relief

- Pain relief for children undergoing surgery was given according to trust paediatric protocols.

Nutrition and hydration

- Parents of children who were coming for surgery were given information about what and when their child could drink before admission.

Patient outcomes

- Parents told us that when their child was discharged from day surgery, they were given clear information about how their child might feel after surgery, and the possible complications to be aware of.

Competent staff

- All staff on the day surgery unit and the outpatient clinics had appropriate training. We were told that mandatory training included health and safety, manual handling, infection control and basic life support. Paediatric life support training was provided regularly.
- A student nurse in the day surgery unit reported good induction on her placement.
- All staff we spoke with said that they had opportunities for career development.

Multidisciplinary working

- We saw evidence of multidisciplinary team (MDT) working in the outpatients clinics; for example, referrals to therapists were discussed in order to improve outcomes for children.
- We were told of the arrangements for young people with chronic conditions to transfer to adult services. MDT discussions started when young people were 14 or 15 depending on their maturity.

Seven-day services

- Neither the day surgery unit nor the outpatients were open at weekends.

Are services for children and young people caring?

Good

We observed good interactions between staff and children. Staff were kind and reassuring to children, and helpful in providing explanations. Parents expressed satisfaction with the nursing and medical support received.

Compassionate care

- We observed a good rapport between staff and children. Parents and children confirmed that staff were friendly and helpful.
- Families made positive comments about the care their children received.
- We saw letters and cards showing positive feedback from families about day surgery.

Patient understanding and involvement

- Parents of children attending clinics for diagnostic tests were sent written information about the tests. They reported receiving good information from staff, and trusted them to provide effective care.
- Children attending for surgery, or their parents, received information about anaesthetics and their planned procedure, as well as information about what to expect post-operatively.

Emotional support

- Parents said that they were emotionally supported by nurses and doctors who explained treatment and lessened their anxiety.

Are services for children and young people responsive?

Good

The services for children at Central Middlesex Hospital were convenient for those living in the area. The day surgery service was well used and met the needs of those it served effectively. However, the outpatient services were only used three days per week. This purpose built unit was the main area for children's outpatient services. Some speciality clinics children are seen in the adult facilities.

Services for children and young people

Service planning and delivery to meet the needs of local people

- The availability of outpatient and day surgery services at Central Middlesex Hospital was useful for those who lived in the area, as it minimised their travel time.
- The outpatient facilities were less suited to children than the similar facilities at Northwick Park Hospital. Some adult outpatients clinics were used for pediatric clinics.

Access and flow

- Day surgery had a low rate of cancellations. Surgical procedures would not be carried out on children if they had been unwell in the preceding ten days.
- The outpatient service saw between 70 and 100 children a month. Staff felt that it was underused.
- Families told us, and the clinic staff confirmed that children with outpatient appointments were seen on time.

Meeting people's individual needs

- The day surgery service was responsive to patients with complex needs and learning disabilities, and we saw that risk assessments were carried out.
- There was access to translation services, and an interpreter could be arranged if required.

Learning from complaints and concerns

- There was information displayed at the outpatient clinics about how to people could provide feedback on the service they had received, and how they could make a complaint.
- We saw information about the Patient Advice and Liaison Service (PALS) available.
- Staff told us that there were very few complaints about either the day surgery unit or outpatient clinics.

Are services for children and young people well-led?

Requires improvement

The day surgery service complemented the similar service at Northwick Park Hospital, and added capacity. It was clear how it fitted into the wider paediatric provision.

However, the Rainbow unit was not well integrated with the main paediatric services of the trust. Nor was it well supervised. The justification for providing outpatient clinics at Central Middlesex Hospital was less clear as the service was not fully utilised. The trust had not considered the risks to this service once the A&E department closes.

Some of the medical staff working at the clinic told us that they felt undervalued.

Governance, risk management and quality measurement

- Clinical governance meetings were held to discuss day surgery incidents, and training sessions were arranged to reinforce processes as necessary. For example, there had been training recently on checking labels and dosages of medicines.
- The Rainbow unit was managed by staff at Northwick Park Hospital, who were rarely on site, and appeared unaware of the quality of the provision. Managers regarded the unit as low risk.
- The medical staff in the Rainbow unit also worked at Northwick Park Hospital, and considered that senior management tended to overlook the services provided at Central Middlesex Hospital. There was no mention of these services in recent board papers.

Leadership of service

- Staff reported that the good integration of acute and community services no longer worked as well as it had in the past. The local boroughs were very different and this presented challenges.
- Staff were not aware of a board level lead for children's services.

Culture within the service

- Staff in the day surgery unit said that there was no blame attached to reporting incidents.
- Some of the medical staff at the clinics felt undervalued and mentioned tensions about the part-time working of some doctors.

Public and staff engagement

- There were no surveys of the views of children and families taken. Children's services did not use the national Friends and Family Test, and only received verbal feedback on the quality of its service.

End of life care

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

Information about the service

Palliative care is provided for all the hospitals in the North West London Hospitals NHS Trust by the specialist palliative care team (SPCT) based in the Macmillan Unit at St Mark's Hospital. Specialist palliative care is advised for patients who are suffering with advanced symptomatic disease, or who are no longer suitable candidates for curative oncological intervention. The SPCT offer support to patients who are coming to end of their life. Outpatients who require palliative care are referred to their community teams as appropriate. Patients could receive palliative care alongside active cancer treatment.

During our inspection we spoke with a number of nurses, junior doctors and consultants on several wards. We spoke with the lead consultant and lead nurse for palliative care, four specialist palliative care nurses, the lead oncology nurse, the bereavement officer, chaplain, a mortuary technician, two porters, a volunteer and two staff from the Macmillan support services. We reviewed records, policy documents, meeting minutes, audit results, the specialist palliative care patient survey and 'thank you' cards. Due to the sensitivity of the patients receiving end of life care at the time of our visit, it was not appropriate to speak to them or to their relatives and friends about the care they were receiving.

Summary of findings

We found that the end of life care to patients was good overall. The hospital had good links with the specialist palliative care team (SPCT) and community services, in order to support patients and their families. The SPCT and other services involved in end of life care were passionate, caring and maintained patients' dignity throughout their care. There was clear multidisciplinary involvement in patient care. Patients were involved in advance care planning and their preferences were observed and followed through, when possible and appropriate. People's cultural and religious needs were taken into account.

End of life care training was not mandatory within the trust, and this meant that healthcare professionals at the hospital found it difficult to attend the courses provided by the SPCT.

End of life care

Are end of life care services safe?

Good

Staff were expected to report all incidents, and they told us that they would always report incidents relating to patient safety. However, they did not always have time to report all incidents due to work pressures, or due to difficulties with the electronic reporting system.

Patient's needs were prioritised at weekly multidisciplinary meetings. The records we reviewed were found to be appropriately completed and medicines were appropriately prescribed. Staff understood how to safeguard patients from abuse, and were aware of the mental capacity act and what to do if someone was unable to give informed consent.

Incidents

- There were no 'never events' or incidents reported to the National Reporting and Learning System (NRLS) relating to end of life care.
- Staff were expected to report incidents through an electronic incident reporting system. Staff told us that they would report incidents relating to a patient's immediate safety on the electronic incident reporting system. However, they all told us that they did not always report other non-patient safety incidents, such as a delay in a patient receiving medication, through the electronic reporting system. They did say however, that they would report such incidents immediately to the most senior member of staff on duty at the time.
- Staff told us that although the electronic incident reporting system was straightforward, it did not allow them to save a report if it had not been fully completed. The SPCT worked across the whole of the hospital, which meant that they may not have all the details relating to the incident to hand (such as names of people present at the time of the incident). In such circumstances, it would rely on them going back to the ward to get the details, which was sometimes difficult after the event. Other reasons for not reporting incidents on the electronic system were a lack of time and a lack of feedback after incidents had been reported.

Safety thermometer

- The trust took part in the National Care of the Dying Audit for Hospitals (NCDAH). The audit is made up of an organisational assessment and a clinical audit. The trust achieved four out of the seven key performance indicators (KPI) in the organisation audit, and eight out of ten for the clinical audit.
- The trust did not achieve 'providing specialist support for care in the last hours or days of a person's life'. This was because they did not provide face-to-face specialist palliative care services from 9am to 5pm, seven days a week, although there is a national recommendation that this should be provided. Nationally, 21% of trusts achieved this. However, there was access to a telephone helpline out of hours.
- The clinical audit marginally fell below the national average in two areas. The trust scored 57% for multidisciplinary team (MDT) recognition that a patient was dying (nationally 59% was achieved); and 48% for medication prescribed when necessary for the five key symptoms (nationally 50% was achieved).
- The trust scored above average in all other areas of the clinical audit, which included nutrition, hydration, spiritual needs, discussions with the next of kin that the patient was dying, plan of care for the dying phase and care after death.

Medicines

- The records we looked at showed that patients whose condition could deteriorate required medicine to alleviate their symptoms. Arrangements were in place to ensure that medicines had been prescribed in advance, so that patient's waiting time and discomfort were minimised.
- The SPCT liaised with GPs and social services to ensure that people received appropriate care once they were discharged from the hospital. Patient's prescription charts showed that they had been prescribed appropriate medicines for palliative care, which included pain relief and anticipatory medicines, such as medicines for nausea and vomiting.
- The palliative care team provided patients who were returning to their home with a supply of their medicines and a leaflet listing the medicines they were taking.
- Some patients received palliative chemotherapy to support their symptoms. There was good multidisciplinary working between the chemotherapy day unit at St Mark's Hospital and the pharmacy department, to ensure that patients received their treatment without unnecessary delay.

End of life care

- Electronic prescribing was in place for colorectal and lung cancer clinics. This meant that information was easily available to all departments to ensure that drug treatments, which are time-consuming to prepare and dependent on blood test results being available, were prepared by the pharmacy on time.
- There were plans to roll out electronic prescribing to other clinics, as we were told that sharing paper-based information, such as blood test results, between departments had the potential to cause delays in the preparation of drug treatment. The unit kept supplies of supportive treatments, such as anti-emetics, to avoid having to send unwell patients to the pharmacy department, and there was good liaison between the unit and the palliative care and community nursing teams.
- Patients receiving chemotherapy on the wards were supported by staff from the day unit.
- We were told that some patients had experienced problems receiving their treatment in the community, because in some areas, community nurses required an authorisation from the GP to administer certain medicines.

Records

- Patients receiving end of life care who had been identified as 'not for resuscitation', had paperwork visible in their notes so that staff were aware of what actions to take.
- We looked at a sample of 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms across a number of wards throughout the hospital. We found that they were completed appropriately and relatives' involvement was recorded. However, the SPCT reported that not all DNACPR forms were completed correctly or completely, and they challenged staff where they found incomplete forms.
- We found that some consultants completed DNACPR records as soon as practicable after the patients arrival to the ward, while other doctors waited at least 24 hours after having the conversation with the patient and their family before completing the forms.
- The SPCT provided patients who were discharged to their home/care home/hospice with an information pack on how to support someone who was dying at home. This included information regarding a person's choice relating to being resuscitated and who had been involved in the discussions. However, we found that the information regarding discussions relating to DNACPR was confusing, as it was not clear as to whether the person wished to be resuscitated or not. This was pointed out to the team, and they planned to change the information immediately to make it clearer for people who may be reading it for the first time.
- The SPCT told us that records completed by the referring healthcare professional were often lacking in information about the patient, which meant that the clinical nurse specialist (CNS) had to make further enquiries to ascertain how quickly the patient needed to be seen.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy and procedure to identify patients who were lacking capacity to make decisions about their care. This was accessible to all staff on the organisation's intranet.
- Best interest multidisciplinary team (MDT) meetings, which involved the clinical staff and palliative care team responsible for the patient's care, took place every week.
- The next of kin/advocate was involved in decisions relating to the care for a patient who could no longer make decisions for themselves.

Safeguarding

- All staff were trained in safeguarding vulnerable adults as part of their mandatory training.
- Macmillan staff told us that they would refer someone who appeared to be at risk of harming themselves, which could be as a result of receiving bad news, to the mental health team or their GP to follow up.
- Staff could access the trust policy and procedure on safeguarding through the internal intranet system.

Mandatory training

- All healthcare professionals had completed their mandatory training.

Assessing responding to patient risk

- The SPCT told us that they would not expect to be asked to attend to every patient who was dying in the hospital, as many of the consultants at the hospital responded appropriately when a patient's condition was deteriorating.
- New patients and urgent cases referred to the SPCT were prioritised and discussed at a weekly MDT meeting.

End of life care

- The ward staff we spoke with were aware of the palliative care team and requested their support if they recognised that a patient was deteriorating or if they needed reassurance that an appropriate course of action was being taken. However, the SPCT reported that some medical staff did not agree with the advice that the clinical nurse specialist (CNS) gave and would, on occasions, continue with a course of curative treatment when a patient was in the latter stages of dying.
- The SPCT checked with nursing and medical staff as to whether a patient had responded to any changes to their treatment.

Nursing staffing

- The end of life team was mainly nurse-led. It consisted of four and a half full-time CNS, including the lead CNS, and a MDT coordinator.
- Some team members were supported and funded by Macmillan. The Macmillan team were not easily identifiable as they did not wear anything to indicate this. We were told by the SPCT that some patients were expecting Macmillan staff to support them and did not identify with the SPCT.
- The bereavement officer was a qualified nurse, and this meant they were able to answer some of the questions that the relatives of the deceased might have about the care and treatment the patient had received, as well as help them to understand the death certificate and cause of death.

Medical staffing

- There were three consultants including the lead clinician. Each consultant worked within the SPCT for one session (0.5 day) per week. The remainder of the time they worked across the hospitals in the trust. This allowed them to have a wide perspective of the patients within the hospital and areas where palliative care was required.

Extended Team

- The bereavement and mortuary services were provided by a private company, their role included transporting bodies from the wards to the mortuary.
- Oncology support and advice was available from staff running the Macmillan kiosk in the main entrance of the hospital.

Are end of life care services effective?

Good

The trust was still using some elements of the Liverpool Care Pathway (LCP) while they reviewed their procedures for the care of a dying patient as recommended by an independent review and following recommendation to phase out the LCP. The team also referred to the London Cancer Alliance for further guidelines.

We looked at a sample of patient records and saw that they received appropriate pain relief, nutrition and hydration. Staff were appropriately trained and supported, and there were regular multidisciplinary meetings.

Evidence-based care and treatment

- Following the independent review of the use of the LCP for the Dying Patient, and the subsequent announcement of the phasing out of use of the LCP, the trust had made some interim amendments, which included the removal of direct and indirect references to the LCP. An essence of the LCP was still in place, as the staff had found that the assessment tools were useful.
- The trust policy and procedure was under review, and there was a steering group reviewing the recommendations to replace the LCP.
- The team referred to the London Cancer Alliance (LCA) for further guidelines.

Pain relief

- The patients we reviewed received appropriate pain relief.

Nutrition and hydration

- The patients we reviewed received appropriate pain relief.

Patient outcomes

- The trust took part in the National Care of the Dying Audit for Hospitals (NCDAH). The trust achieved four out of the seven key performance indicators (KPI) in the organisation audit, and eight out of ten for the clinical audit.
- The SPCT had analysed the main findings of the audit and proposed a number of recommendations to improve the service provided.

End of life care

- The trust opted out of the bereavement audit summary as a majority of patients' notes did not contain the next of kin details, so they were unable to obtain bereaved relatives views.
- The SPCT had good links with the community palliative care team, so that patients could receive continued support within the community.
- The team accessed the electronic data system 'co-ordinate my care' for patient's using the system.

Competent staff

- All nursing staff had annual appraisals on their performance with their manager.
- Staff had a supervision meeting with their manager once every six months.
- The CNS and consultants were required to complete continuing professional development courses, and they attended various other courses relating to their role in end of life care.
- The team had increased their profile with the trust; however, this had led to an increased referral rate across the trust, from 450 in 2012 to 1,000 in 2013. Staff resources were stretched, as their workload had doubled and the staff numbers had remained the same.
- End of life training was offered by the SPCT to all staff within the trust. However, this was not currently mandatory as recommended nationally.
- The end of life training included communication training, how to have difficult conversations, identifying the signs of dying, and policies on syringe drivers.
- The SPCT team told us that it was difficult to engage junior doctors and consultants in the training, and nursing staff found it hard to attend due to work pressures. 25% of staff had undertaken training.
- The private company, which was responsible for the bereavement office and mortuary, arranged for people's bodies to be transported from the wards to the mortuary.
- Some of the SPCT CNS's were taking qualifications to become nurse prescribers. This meant that they would be able to prescribe appropriate medication, as well as advise on them.
- The bereavement office assisted junior doctors on how to fill out the medical certificate of death in order to prevent the registry office rejecting them for being completed incorrectly. This meant that distress to families would be minimised.

Multidisciplinary working

- Multidisciplinary palliative care meetings were held weekly. New and complex cases were discussed. We were told that the chaplaincy team were invited to these meetings, but rarely attended. The chaplaincy told us that they were unaware that they were invited to attend the meetings.
- The extended multidisciplinary team members were invited to attend the end of life team's annual operational meeting, so that they could to agree to its operational policy.

Seven-day services

- The SPCT was available at the hospital from 9am to 5pm from Monday to Saturday.
- Out-of-hours support services were provided by Michael Sobell Hospice at Mount Vernon Hospital.

Are end of life care services caring?

Good

During our inspection we did not speak with any patients or their families/friends about the end of life care services, as it was a sensitive time for people, and it was felt that it was not appropriate to intrude on their circumstances. We observed staff treating people with compassion, dignity and respect. Other staff were able to explain how they cared for and supported people.

Records showed patients and their families were involved in discussions relating to their care. A named ward nurse was allocated to patients for continuity of care. There were other support services available, such as a multi-faith chaplaincy and Macmillan cancer care services.

Compassionate care

- During our inspection we saw patients being treated with compassion, dignity and respect. 'Thank you' letters showed how much patients and their families valued the support, advice and care that the SPCT gave to them.
- Staff spoke passionately about how they cared and supported people.
- Normal visiting times were waived for relatives of patients who were at the end of their life.

End of life care

- The SPCT told us they encouraged ward staff to sit with patients who did not have regular visitors at the end of their life.
- If appropriate, a patient was moved to a side room to offer more privacy when they were nearing the end of their life. If this was not possible, curtains were drawn around their beds.
- Deceased patients were moved from the ward to the mortuary as soon as was practicable.

Patient understanding and involvement

- Patients were given a named nurse on the wards.
- The clinical nurse specialists (CNS's) were not allocated to individual patients, as they were required to support a number of patients over all the hospitals. The team tried to ensure that no more than two CNS supported one patient in order to maintain continuity in their care.
- Patient records that we viewed showed that conversations regarding end of life care, which had taken place between healthcare professionals, patients and their families, were recorded.

Emotional support

- CNS supported patients and their relatives. People were given as much time as they needed to talk about their thoughts and feelings.
- Macmillan staff were available at the hospital, and provided support to friends and relatives.
- Patients had assessments for anxiety and depression, and appropriate clinical support was offered.
- Multi-faith chaplaincy was available to provide spiritual support.
- The bereavement officer supported relatives/friends after the patient's death by explaining all the legal processes, and what to expect after someone has died. They provided an information pack which included the contact details for support and counselling groups.

Are end of life care services responsive?

Good

Overall, we found the end of life care service to be responsive to people's needs. It had been identified by the SPCT and the NCDAH that some staff did not recognise the stages of dying, which meant that some patients may continue to receive curative medicines which might not be appropriate. However, the number of patients referred by healthcare professionals to the SPCT had doubled in the last year, which meant that more staff were recognising the signs of a deteriorating patient.

Most wards/departments did not have an adequate room where sensitive conversations could be held with families. However, patients coming to the end of their life were moved into side rooms if appropriate, in order to allow privacy.

Service planning and delivery to meet the needs of local people

- The SPCT knew how many patients they were supporting with end of life care. However, we were not able to identify how many patients in the entire hospital were receiving end of life care with support from the ward staff and their consultant.
- The SPCT profile had increased over the last year and their workload had doubled, as more staff referred patients to them. However, the team size had remained the same. The staff reported that this meant they were often completing reports in their own time at the end of their shift to allow them enough time to spend with patients and their families.

Access and flow

- Patients whose condition was identified as deteriorating could be referred to the SPCT by any healthcare professional in the trust. The community palliative care team could refer patients to be admitted to the hospital.
- Based on figures from the period September 2012 to the end of February 2013, on average half of the patients referred to the SPCT were referred by doctors, the remaining half were referred by ward staff and specialist nurses.
- Hospital staff had access to an electronic co-ordination system to refer patients to the SPCT.
- 60% of patients were receiving palliative care for cancer-related illness; 40% were non-cancer related.
- Patients were seen by a CNS within 24 hours of referral for urgent cases, and within three days for non-urgent cases. We saw that all referred patients had been seen within the relevant time scales.
- Patients who had a terminal illness were supported in being discharged to a place of their choice. This could be achieved within 24 hours if all the relevant assessments and community resources were readily accessible. The CNS administered the discharge for

anyone under their care. This was a lengthy process and could take them up to five or six hours. This meant they were taken away from spending time with other patients. The CNS we spoke with told us that they would value administrative support to assist them with discharges and allow them more time with patients.

Meeting people's individual needs

- The SPCT had identified that some healthcare professionals did not always recognise the early stages of dying and therefore, on occasions, continued with curative treatment when it was not appropriate.
- Interpreters were available for people who were unable to understand English.
- A multi-faith chaplaincy was available. There were full-time Church of England and Catholic priests, and part-time Muslim, Jewish and Hindu spiritual leaders available.
- We were shown a breakdown of where people wished to die against the number who actually died in their preferred place. However, this had not been fully completed since February 2013. The six months prior to that showed that a majority of people did not die in their preferred place. We were unable to ascertain the reason for this.

Learning from complaints and concerns

- Complaints were monitored by the lead CNS. Any learning and patterns were identified and discussed at the team meetings. The SPCT had received three complaints in the last year, and they had all been investigated appropriately by the complaints department.
- The chaplaincy ran a multi-faith user group, where they discussed patient care. One concern raised related to staff not being aware of religious days or festivals for different faiths. As a result of this, a multi-faith calendar was produced and placed in multiple locations within the hospital. This meant that staff could support patients with their faith. We noted that the calendar did not indicate what was required on the given day, such as wearing particular clothing or fasting times, so staff were not made aware of what the event meant to the individuals to whom it related.

Facilities for relatives

- There was a prayer room, a quiet room, and a chapel. There were bathroom facilities which included a foot bath.

Are end of life care services well-led?

Good

We found that overall, the end of life care services were well-led. The trust had recently appointed a non-executive director to lead on end of life care. It was too early to say if this would raise the profile of the service at board level and increase the focus on providing good end of life care for every patient within the trust.

We found strong positive leadership across all the services involved in end of life care. All staff were passionate about their work in supporting and caring for patients and their families. Patients, their families and staff were asked for their views of the service. The SPCT were undertaking a number of research programmes to find ways to reduce the number of unnecessary hospital visits for patients nearing the end of their life.

Vision and strategy for this service

- The end of life team had an annual general meeting, where they discussed and agreed their operational policy, and work plans and priorities for the following year. This included the Macmillan, bereavement and chaplaincy services.

Governance, risk management and quality measurement

- Palliative care and oncology clinical governance meetings took place every three months.
- MDT team meetings took place every week. Complaints, concerns or issues were raised, discussed and planned for.
- The clinical lead told us that the MDT relationship was not as robust as it could be, and they were in the process of establishing a more integrated model of working to include the hospital discharge teams and community services

Leadership of service

- Many of the staff we spoke with said that they would not know the executive board members and had not seen them on the wards engaging with staff and patients.
- The trust had recently appointed a non-executive director to lead in end of life care. The lead clinician and

End of life care

CNS spoke positively of this appointment, and felt that the future would be positive. However, it was too early to say whether this would increase the profile of end of life care within the trust.

- The lead clinician and lead CNS were responsible for the day-to-day running of the team. They were very energetic and had a positive vision for end of life care within the trust.
- All the CNS felt supported by the management team, and shared in the department's vision to provide a caring and responsive approach for people requiring palliative care.
- The management team and staff all agreed on the challenges and pressures they faced.
- The privately-run bereavement office and mortuary reported a good working relationship with the hospital.

Culture within the service

- Most of the staff we spoke with were unsure of the future of the hospital and what it would mean for their role. They all felt that any progression had been put on hold due to the merger plans.
- Staff we spoke with in relation to end of life care spoke positively and passionately about the work they did in supporting patients approaching the end of their life, and supporting the family and friends during and after the patient's death.
- The SPCT and Macmillan support services worked closely together, and supported each other in ways to improve the patient's experience. This was paralleled by the bereavement office, mortuary and chaplaincy.
- Most of the staff we spoke with on the wards were aware of the SPCT. However, many of them were not aware of the training that the team offered.
- Staff reported that it was difficult to be released from the wards to participate in extra training as work pressures often prevented them from attending voluntary courses.
- Staff told us that it was difficult to engage junior doctors and consultants in end of life care training.

Public and staff engagement

- Relatives/friends of people who died at one of the trust's hospitals were invited to complete a survey. Between March and October 2013, 100 surveys were given out. 16 completed surveys were received. Staff told us that the return rate was probably low because they related to a very sensitive subject, which people may not want to think about.
- The department used learning outcomes from the NCDAH audit to improve their services.
- Staff told us that they would engage with people at the time if there were any concerns.
- We saw there were a number of 'thank you' letters from relatives outlining areas of care they appreciated, such as support and comfort.
- The CNS within the SPCT felt involved and supported in putting forward any ideas they had to improve the service they offered.
- Staff who attended courses run by the SPCT were asked their opinion of the training. A majority indicated that the courses helped them considerably in recognising a dying patient and how they could support them.

Innovation, improvement and sustainability

- The SPCT implemented a study in improving the outcomes for patients by establishing an integrated heart failure (HF) pathway. The aim of the project was to develop an integrated approach to the assessment and care of patients with advanced HF, to ensure better identification, palliation of needs and choices at the end of life. The results improved cardiac and palliative care for patients, improved the use of hospice and community services, and reduced the number of inappropriate admissions to hospital. It gained huge endorsement from community HF nurses.
- As a result of the success of this study, the SPCT secured two Darzi fellows to lead a service development programme to reduce the number of admissions to hospital for patients with long-term conditions, or who were frail in the last years of their life.

Outpatients

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

Information about the service

Central Middlesex Hospital is one of three locations run by the North West London Hospitals NHS Trust, which last year provided a service to 374,000 outpatients.

The outpatient clinics are located throughout the hospital. Each clinic is held in a designated location which is termed a 'pod'. These have their own waiting areas. Individual clinics are run in these areas with their own reception desks. Some areas run two clinics, and the administrative staff are also located within the individual clinics. Clinics are organised and run by a co-ordinator, with some co-ordinators being responsible for more than one clinic. There is a senior coordinator who has overall supervisory responsibility and reports to the general manager of outpatients, who is based primarily at Northwick Park Hospital.

During our inspection we visited the clinics for rheumatology, dermatology, diabetes, orthopaedics and urology. We met with 10 staff including receptionists, nursing staff, healthcare assistants, consultants, administration staff and clinic coordinators. We spoke with six patients. We looked at the patient environment, and observed waiting areas and clinics in operation.

Summary of findings

Patients received compassionate care and were treated with dignity and respect by staff. The environment was clean, comfortable, well maintained and safe. Staff were professional and polite, and promoted a caring ethos.

Clinicians took sufficient time in consultations, and patients said that they felt involved in their care. Clinics started on time and generally ran to schedule. The rheumatology clinics were regularly oversubscribed and had long waiting times, but action was being taken to recruit an additional consultant.

Outpatients

Are outpatients services safe?

Good

The patient outpatient areas were clean and well maintained. Infection control procedures were followed and regular audits were completed. Patient records for the individual clinics were kept securely. Medication was securely stored, and regularly checked and audited.

Patients we spoke with told us that they thought the outpatients department was a safe place to visit for treatment.

Incidents

- There had been no 'never events' or serious incidents reported in the outpatients department.

Cleanliness, infection control and hygiene

- We visited the waiting areas for all of the clinics and also saw six of the consulting rooms. All were clean and well maintained. Patients said that the consulting rooms were always clean. One patient told us "yes this place is always clean, I cannot fault it".
- An external contractor provided the cleaning service and was also responsible for building maintenance. Staff told us that if additional cleaning was required, the request was responded to promptly. We were also told that when maintenance was required which impacted on health and safety, action was taken quickly.
- Daily infection control audits were completed by the nursing staff, and monthly audits by the infection control lead for the hospital.
- The toilet facilities were regularly checked and cleaned.
- 'Bare below the elbow' policies were adhered to in the clinical areas.
- Hand hygiene gel dispensers were provided in the access areas to all the various clinics, with reminders about their usage for patients and staff. We observed these being used by patients and staff.
- Staff completed infection control training as part of their core mandatory training.

Environment and equipment

- Outpatient clinics were located throughout the three floors of the main hospital building. We visited all of the clinic areas, and they all were comfortable and well maintained. The manager explained that the outpatient clinics had been purpose-built. The building provided a safe environment for patients. Clinics were well signposted and easily accessible to patients.
- Resuscitation equipment was located on each floor. All equipment was checked daily by the nursing staff and checks were recorded. The equipment was also checked regularly by the hospital's resuscitation team.
- Equipment used in the clinical areas was correctly serviced and maintained. Records reviewed confirmed this. Equipment that had been serviced was labelled and dated. Audits were completed on the servicing of equipment.

Medicines

- Medicines were stored correctly in locked cupboards or fridges where required. The cupboards were checked daily by the nursing staff, and inspections were also carried out by the pharmacy department. We spoke with one nurse, who described how they checked the medication storage and recorded this information.
- Patients we spoke with told us that they received appropriate information about the medication they were prescribed, and that changes to their medication were explained to them.
- Written information about medication was only available in English. This could mean that for some patients there could be difficulties in understanding the directions.

Records

- Patient records were held in the reception area for each clinic. Records could be moved between clinics using a trolley. We saw on one occasion that some records were left unattended momentarily. However, the staff member had turned the notes over to protect people's confidentiality.
- Temporary notes were in place at some of the clinics. An explanation was supplied with the notes as to why the full set of notes was not in place. This was often due to a patient having been seen at another hospital within the previous 24 hours and there not being sufficient time to transport the notes.
- Information about patients was also available electronically.

Outpatients

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients gave their consented appropriately and correctly. Patients we spoke with told us that the clinical staff asked for their consent before commencing any examination or procedure.

Safeguarding

- All nursing and other healthcare staff we spoke with confirmed that they had completed safeguarding training, and were aware of the procedure to follow should they need to report a concern.
- Information about safeguarding was displayed in several parts of the outpatients area.
- Patients we spoke with told us that they thought the outpatients department was a safe place to visit for treatment.

Mandatory training

- All staff were required to complete a range of mandatory training, which included fire safety, safeguarding, moving and handling, and infection control. Staff told us that they had completed this training and also any required updates. Staff were aware of their responsibility to ensure that they were up to date.
- The co-ordinator of each clinic checked mandatory training as part of the staff's annual appraisal process.

Staffing

- Each clinic had its own reception area which accommodated the support staff for that clinic. There were enough staff to ensure that patients were attended to within a reasonable timescale. The clinics we visited all had their designated staffing levels in place.

Major incident awareness and training

- In case of a failing of the electronic booking system, each clinic had a paper record of the day's appointments.
- All staff completed training in fire safety, and nominated staff were designated fire wardens with allocated responsibilities in the event of a fire.

Are outpatients services effective?

Not sufficient evidence to rate

We report on effectiveness for outpatients below. However, we are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients.

Evidence-based care and treatment

- We were told that guidelines, such as NICE guidelines, were followed where appropriate.
- Staff were aware of how to access policies and procedures online. Nursing staff told us how new practice guidance was cascaded, either through the department, or through the specialist area they were working in.

Patient outcomes

- Patients we spoke with were positive about the outpatients clinic service. One person told us "they are great and the doctor is amazing". Another person said "they always listen to me and when my medication changed the doctor explained all the reasons and the side effects I might look out for, she was really excellent".
- We were told by two co-ordinators and a consultant that the outpatients department was helped by having many of the doctors who ran clinics based at the Central Middlesex Hospital site. We were told that this helped with continuity of care, and promoted good communication between the clinic staff and the medical staff.

Competent staff

- Staff we spoke with told us they had annual appraisals on their performance, and this was monitored by the pod co-ordinators. When appraisals were due, any mandatory training that a staff member needed to complete was also brought to the attention of their manager.
- We spoke with two consultants, and they told us that they were supported by a professional team of staff. We were told that the teams were well organised and skilled in their various roles.

Seven-day services

- The outpatient service provided a Monday to Friday service.

Outpatients

Are outpatients services caring?

Good

We found that the outpatient services at Central Middlesex Hospital were focused on patients and committed to providing a positive experience of treatment. We observed staff interacting with patients in a caring and respectful manner. All the patients we spoke with told us that the staff were caring and polite.

Compassionate care

- All the patients we spoke with were very positive about the approach of the staff. We were told that staff treated people with respect, and were polite and caring. One patient told us "the doctor does regular monitoring and reviewing of my medication and explains things carefully".
- People we spoke with told us that they felt listened to and were given time to ask questions.
- Patients' confidentially was respected. Patients and staff told us that there were always rooms available to speak to people privately and confidentially.
- Two patients commented that the staff were "very committed and knowledgeable" and one said "I feel like I am not just a number when I come here, they take their time".

Patient understanding and involvement

- Patients we spoke with told us that they were involved in their care. They told us that the nursing staff and consultants explained things clearly and always answered any questions.

Emotional support

- Staff told us they would be aware when a patient may have received difficult or distressing news, and would offer to talk to them privately after their consultation. Staff would also ensure that patients were aware of any appropriate support services they might wish to use. One patient we spoke with told us, "it has been a difficult time but the doctor and staff have been absolutely brilliant".

Are outpatients services responsive?

Good

Clinics generally ran on time, and action was being taken to address the high demand for rheumatology and orthopaedic clinics. The flexibility of the role of the clinics care co-ordinators helped the service respond quickly when additional support was needed.

Service planning and delivery to meet the needs of local people

- Data supplied showed that the trust provided an average of 500 clinics a month for between 27,000 and 33,000 patients.
- Extra clinics could be arranged in conjunction with the specialist departments, to accommodate more patients.

Access and flow

- At Central Middlesex Hospital staff and patients told us that the clinics usually ran on time and that patients did not have to wait long for their consultations. The main exception to this was the rheumatology clinic, which struggled to meet the demand for appointments. We were also told that there could be delays in the orthopaedic clinics. Action was being taken to improve waiting times. We were told that recruitment was being organised for additional consultants for both of these clinics.
- There was a degree of flexibility when patients booked appointments, though this depended on the clinic concerned.
- A trial had been run using texting to remind patients of appointments, but the trust had decided not to implement this as a permanent service.

Meeting people's individual needs

- Patients could be provided with transport following an assessment of their eligibility. Information about this service was displayed in the waiting areas. Staff told us that they would also check with patients to see whether they wished to apply for this service.
- Staff said they would liaise with carers and relatives when someone with complex needs had an appointment, to ensure that they had the correct support to attend their appointment. One healthcare assistant explained how they had contacted a care home to ensure that an elderly patient visiting later that day had their transport correctly arranged.

Outpatients

- In the older people care clinic, patients were telephoned the day before their appointment as a reminder, and also to ensure that they had their transport arranged. Also, patients who failed to arrive for oncology appointments were contacted by the clinic staff, and if they were able to travel to the hospital that day, the consultant would see them.
- There were systems in place for staff to use an interpreting service. It could be arranged for an interpreter to be present or accessed via a phone link.

Learning from complaints and concerns

- Data from the trust showed there had been no formal complaints made about the outpatients department in the previous 12 months.
- The co-ordinators told us that they attempted to resolve concerns informally by talking to patients. We were told that the only issues they had dealt with in the previous 12 months were concerning appointments running late or being cancelled. Information about making complaints was displayed in the outpatients area. Senior staff we spoke with were aware of the trust's complaints policy and the procedure to be followed. Information was also displayed regarding the Patients Advice and Liaison Service (PALS).

Are outpatients services well-led?

Good

There was a strong caring ethos within the outpatients department, and staff were patient-focused. Staff were clear about the management structure and the lines of accountability. Managers and senior staff were approachable and staff felt listened to.

Leadership of service

- Staff we spoke with were positive about the management and leadership provided in the outpatients department. They said that they worked as a team, and were confident about approaching the senior staff about concerns or to ask for advice.
- We were told that senior staff were approachable and supportive.
- Each pod area held monthly meetings for all the staff. The co-ordinators also held monthly meetings with the medical staff. We saw the minutes from staff meetings, which showed that information was being cascaded down to staff, and also general issues were being raised and discussed. For example, one area of discussion had been a reminder to staff to be aware when some clinics may be short staffed at short notice, and extra support could be offered. The pod co-ordinators also met every two weeks as group.

Culture within the service

- All the staff we spoke with were positive about the model of outpatients that was being operated. Two of the co-ordinators we spoke with said that they were proud of the service that was being delivered, and believed that the department was positively focused on meeting patient needs. One healthcare care assistant we spoke with told us "I think this is a great environment to work in, I really love it".

Public and staff engagement

- Staff were aware of the distribution of trust information via a briefing called 'Team Talk' on the intranet, and also of the hospital magazine which was produced quarterly.
- Several staff had also attended the staff open forums which had been held in the hospital with members of the trust board. These meetings were held on average every three months.
- Senior staff we spoke with said they were kept informed about trust developments and felt that they were an important part of the organisation.

Innovation, improvement and sustainability

- The outpatients department had developed a new role titled 'clinical care co-ordinator'. These staff combined administration skills with healthcare assistant skills, which enabled them to move between the two roles. This provided greater flexibility for covering staff absence, as people could be asked to move temporarily at short notice to support another clinic if required. Staff who had taken on this new role told us that it gave them greater job satisfaction. They also said that they believed it helped the department provide a better service to patients. The manager told us that this development was key to the flexibility that was needed to run the department smoothly.

Outstanding practice and areas for improvement

Outstanding practice

- The STARRS service had strong ownership by geriatricians and the multi-disciplinary team. The team was aware of the needs of frail elderly patients who attend A&E. It was introduced by the trust and its partners to mitigate one of the pressures on the A&E service and the hospital's beds.

Areas for improvement

Action the hospital SHOULD take to improve

- Review the lack of a paediatric nurse in the children's outpatient department.
- Ensure that critical care services are audited in line with others, so that benchmarking can take place to drive improvement.
- Review the end of life care provision at this hospital, so that patients receive intervention at an appropriate stage.
- Ensure that departments where children are treated are child-friendly.
- Review epilepsy services for children to ensure that current guidance is in place.

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North West London Hospitals NHS Trust

Northwick Park Hospital

Quality Report

Watford Road
Harrow
Middlesex
HA1 3UJ
Tel: 020 8864 3232
Website: www.nwlh.nhs.uk

Date of inspection visit: 20-23 May 2014
Date of publication: 20 August 2014

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Requires improvement
Accident and emergency	Requires improvement
Medical care	Good
Surgery	Requires improvement
Critical care	Inadequate
Maternity and family planning	Requires improvement
Services for children and young people	Requires improvement
End of life care	Good
Outpatients	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out this comprehensive inspection because North West London Hospitals NHS Trust had been identified as potentially high risk on the Care Quality Commission's (CQC) Intelligent Monitoring system. We carried out an announced inspection of Northwick Park Hospital between 20 and 23 May 2014. Northwick Park is the main location of the trust and accommodates the senior management team.

North West London Hospitals NHS Trust is located in the London Boroughs of Brent and Harrow, and cares for more than half a million people living across the two boroughs, as well as patients from all over the country and internationally. The North West London Hospitals NHS Trust manages three main sites registered with the Care Quality Commission: Northwick Park Hospital and St Mark's Hospitals in Harrow, and Central Middlesex Hospital in Park Royal. St Mark's Hospital as an internationally-renowned centre for specialist care for bowel diseases. The trust has a sustainable clinical strategy with Ealing Hospital to improve patient pathways, and is underpinned by combined ICT and estate strategies, and a vision to establish Northwick Park Hospital as the major acute hospital of choice for outer North West London.

The hospital has had some issues in the past, particularly around its maternity services. However, the management team has worked hard to address these. We saw a number of areas where improvements had been made to the maternity services, but it still requires further improvements in order to provide a safe, effective, caring and responsive service.

Overwhelmingly across the trust, staff were found to be caring and compassionate towards patients, their family and friends. The management of areas at a local level required some improvement for services to develop and provide good care.

Our key findings were as follows:

- The patient flow through the hospital impacted on patients waiting in the A&E department, in that patients were often 'bedded down' in A&E until a bed became available.
- Middle grade doctors did not always receive the training and supervision they required.
- Policies and protocols, particularly in surgery and critical care, were not always up to date and reflective of national guidance.
- Pressures on the critical care units were such that some patients were discharged too early and had to be re-admitted on some occasions.
- The pace of change in maternity was slow, leading to potential risks for women using the service.
- In most areas the hospital, while clean, was in need of refurbishment.

We saw an area of outstanding practice:

- The stroke unit was providing a 'gold standard service' with seven-day working. It had been the recipient of the prize for the 2013 Clinical Leadership Team at the British Medical Journal awards.

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

Importantly, the trust must:

- Ensure that there are appropriate numbers of staff to meet the needs of patients in the A&E department, surgical areas and critical care.
- Ensure that there are systems in place to assess and monitor the quality of the service provided in A&E, critical care, surgery and maternity, to ensure that services are safe and benchmarked against national standards.
- Ensure that the environment is safe and suitable in paediatric services.
- Ensure that equipment is available, safe and suitable within the paediatric service.

Summary of findings

In addition the trust should:

- Review the coping strategies within A&E during periods of excessive demand for services.
- Empower senior staff to make changes to ensure that patients are safe in A&E and maternity.
- Ensure that planned changes are undertaken in a timely manner in surgery and in maternity.
- Review discharge arrangements in A&E and critical care to avoid re-admission to these areas.
- Encourage a proactive midwifery department.
- Encourage increased multidisciplinary working in areas such as maternity.
- Review the confidentiality of medical records within the outpatients department.
- Review the effectiveness of clinics to prevent overbooking, late running and cancellations.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Accident and emergency	Requires improvement 	The A&E department at Northwick Park Hospital required improvement in order to protect people from avoidable harm. There were inadequate staffing levels to provide safe care to patients within the majors treatment area. The escalation protocol was inadequate and did not provide a sufficient or measurably safe response. Northwick Park Hospital was consistently not meeting the four-hour A&E waiting time target. The leadership within the A&E department did not ensure that patient experience and flow through the department was assured. The staff we spoke with demonstrated an attitude of commitment, but their morale was low. However, staff took the time to listen to patients and explain to them what was wrong and any treatment required. Patients told us that they had all their questions answered and felt involved in making decisions about their care.
Medical care	Good 	Care and treatment in the medical services were based on published guidance, and there was evidence that outcomes for patients were good. Safe staffing levels had been set and were maintained by the use of bank and agency staff. Patients we spoke with told us they had been treated with dignity, shown respect and had been well cared for by staff. We found that there was strong and enthusiastic leadership shown by directorate management teams, including matrons and ward managers. The environment and equipment were visibly clean, and infection control practices were good. Care was organised to meet the needs of the patient, and translation services were available. There was a multidisciplinary approach involving patients and relatives to ensure the safe and effective discharge of patients from hospital.
Surgery	Requires improvement 	The surgical service at Northwick Park Hospital requires improvement. Whilst the day-to-day running of the department generally provided safe care, the service faced notable risks. The low number of middle grade doctors and the low number of general surgical lists meant that there

Summary of findings

were delays in emergency surgery taking place. Nursing staff received appropriate training and support, and multidisciplinary working was good. However, there was a lack of up-to-date protocols and guidelines for staff to work from. Patients said that they were well looked after and supported, and we observed this taking place.
While the concerns highlighted had been raised internally, and plans to improve the department had been drawn up, these changes had not occurred. It was not clear if there was a specific plan for when these planned adjustments would be made.

Critical care

Inadequate

The critical care unit (CCU) at Northwick Park Hospital is inadequate as there was insufficient data recording of activities and outcomes to ensure that the services provided a good practice. The service cannot benchmark itself against national data as it had chosen to undertake a local auditing system. However data was not robustly and consistently being collected. Nursing staff were supported through good policies and protocols, however despite the large numbers of locum medical staff used there were no guidance or protocols for them to treat patients in line with. This could potentially lead to inconsistent care being provided.
Whilst there was only limited information to indicate that instances of harm had occurred in the past, there were insufficient measures in place to ensure that patients were safe and received high quality care. Pressure on the department meant that some patients were discharged too early and had to be readmitted on some occasions. There was a lack of departmental senior staff to take action on these issues, and senior staff at the trust had not acted on the concerns. Despite the pressure staff were under, they were seen to be caring and supportive of relatives.

Maternity and family planning

Requires improvement

The maternity service was not meeting some of its performance targets. Although risks to the service had been identified and were being monitored, there was a lack of pace in taking action to minimise risks to women using the service.
We saw that there were efforts being made to introduce changes that would deploy the midwife workforce more flexibly, but further effort was needed to win staff support and embed these

changes for the benefit of women and their babies. The maternity service did not respond to complaints in a timely manner, nor did it actively seek women's feedback on the maternity pathway. Women reported to us and through a number of surveys that the care they received fell below expectations.

Services for children and young people	**Requires improvement**		Services for children and young people at Northwick Park Hospital require improvement. Children received effective care from staff trained to work with children. Staff engaged well with children of different ages. The facilities were generally good, particularly in the day care/children's outpatient area. Staffing and skill mix on the ward, the neonatal unit and the day care/outpatient service were sufficient. However, there was insufficient space for storage of equipment on the children's ward, and some areas were cluttered. Parents had confidence in the care their children received, and spoke positively about staff's compassion and communication. We observed staff showing care and responsiveness to individual children. However, we found some areas where safety needed to be strengthened, such as ensuring clinical equipment was not accessible to children on the inpatient ward, and that medical equipment was serviced annually. There were arrangements to meet the diverse language needs of the population served by the hospital. However, there was a lack of joined up working across the medical team and between doctors and nurses. We also found that the service itself was distant from the trust board. There were no processes to obtain the views of the service from families and friends, although we were told that some ideas were being considered.
End of life care	**Good**		We found that the end of life care to patients was good overall. The hospital had good links with the specialist palliative care team (SPCT) and community services, in order to support patients and their families. The SPCT and other services involved in end of life care were passionate, caring and maintained patients' dignity throughout their care. There was clear multidisciplinary involvement in patient care. Patients were involved in advance

Summary of findings

			care planning and their preferences were observed and followed through when possible and appropriate. People's cultural and religious needs were taken into account. End of life care training was not mandatory within the trust and this meant that healthcare professionals at the hospital found it difficult to attend the courses provided by the SPCT.
Outpatients	**Requires improvement**		Patients received compassionate care and were treated with dignity and respect by staff. The outpatients environment was clean, reasonably comfortable, well maintained and safe. Staff were professional and polite, and promoted a caring ethos. Patient notes for the individual clinics were kept in open trolleys and we saw that on occasions, these were left unsupervised. The lack of secure storage meant there was the possibility of confidentiality being breached. Clinicians took sufficient time in consultations, and patients said that they felt involved in their care. The demand for some of the clinics was greater than the capacity. This meant that some clinics ran late and also had long waiting times for appointments. There were initiatives in place to consider moving some services to improve their efficiency.

Requires improvement

Northwick Park Hospital

Detailed findings

Services we looked at
Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Maternity and family planning; Services for children and young people; End of life care; and Outpatients

Contents

Detailed findings

Background to Northwick Park Hospital

Northwick Park Hospital is part of North West London Hospitals NHS Trust and has 658 beds. The Hospital is a hub for major acute services. This CQC inspection was not part of an application for Foundation Trust status. The trust is currently undergoing a merger with Ealing Hospital NHS Trust, which is scheduled to become effective in October 2014.

Northwick Park Hospital is in the London Borough of Harrow, and lies to the north-western outer ring of Greater London bordering on the county of Hertfordshire. The population of Harrow is 239,056 as recorded in the 2011 Census. The GP registration data shows that the percentage of the population registered with a GP in Harrow is 96.2%. Of 326 local authorities, Harrow is the 194th most deprived. In Harrow, 57.8% of the population belong to non-White minorities. Of these, the Asian ethnic group constitutes the largest ethnic group with 42.6% of the population.

Over the last 10 years in Harrow, all-cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen and are better than the England average. Life expectancy for both men and women is higher than the England average. Life expectancy is also 8.1 years lower for men and 4.2 years lower for women in the most deprived areas of Harrow than in the least deprived areas.

The trust was selected for inspection as an example of a 'high risk' trust.

Our inspection team

Our inspection team was led by:

Chair: Alastair Henderson, Chief Executive, Academy of Medical Royal Colleges

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission (CQC)

The team included CQC inspectors and analysts, doctors, nurses, patient 'experts by experience' and senior NHS managers.

How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Services for children and young People
- End of life care
- Outpatients

Before visiting, we reviewed a range of information we hold about the hospital and asked other organisations to share what they knew about the hospital. We carried out an announced visit between 20 and 23 May 2014. During the visit we held focus groups with a range of staff in the

hospital, including doctors, nurses, physiotherapists, occupational therapists, porters, domestic staff and pharmacists. We also interviewed senior members of staff at the hospital.

We talked with patients and staff from various areas of the hospital including the wards, theatre, outpatients department and the A&E department. We observed how patients were being cared for and talked with carers and/or family members, and reviewed treatment records of patients. We held three listening events where patients and members of the public shared their views and experiences of the hospital.

Facts and data about Northwick Park Hospital

Key facts and figures about the trust

- Northwick Park - 658 Beds
- St Mark's - 64 Beds
- Central Middlesex - 180 Beds
- Inpatient admissions -107,202 2012/13
- Outpatient attendances - 343,967 2013/14
- A+E attendances - 223,343 2012/13
- Births - 5,609 Oct 12 to Nov 13
- Deaths (and by location)
- Annual turnover
- Surplus (deficit) - £20.5m deficit

Intelligent Monitoring

Safe - Risk: 2; Elevated: 0; Score 2

Effective - Risk: 2; Elevated: 0; Score 2

Caring - Risk: 2; Elevated: 3; Score 8

Responsive - Risk: 0; Elevated: 2; Score 4

Well led - Risk: 2; Elevated: 0; Score 2

Total - Risk: 8; Elevated: 5; Score 18

Individual Elevated Risks

- Maternity Survey 2013 C2 "During your labour, were you able to move around and choose the position that made you most comfortable?" (Score out of 10)
- Maternity Survey 2013 C12 "Did the staff treating and examining you introduce themselves?" (Score out of 10)
- Maternity Survey 2013 C13 "Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?" (Score out of 10)
- Composite indicator: A&E waiting times more than 4 hours
- Composite indicator: Referral to treatment

Individual Risks

- 'Never event' incidence
- Potential under-reporting of patient safety incidents
- PROMs EQ-5D score: Knee Replacement (PRIMARY)
- Proportion of patients who received all the secondary prevention medications for which they were eligible
- Maternity Survey 2013 C14 "If you raised a concern during labour and birth, did you feel that it was taken seriously?" (Score out of 10)
- Maternity Survey 2013 C18 "Thinking about your care during labour and birth, were you treated with respect and dignity?" (Score out of 10)
- Healthcare Worker Flu vaccination uptake

Safe:

Never events in past year - 4

Serious incidents (STEIs) - 126 Between Dec 2012 and Jan 2014

National Reporting and Learning System (NRLS)

Deaths	9
Serious	17
Moderate	190
Abuse	30
Total	**246**

Effective:

HSMR - No evidence of risk

SHMI - No evidence of risk

Caring:

CQC inpatient survey - **average**

Cancer patient experience survey - **below**

Responsive:

Bed occupancy - 92.9%

Average length of stay - _____

A&E: 4 hour standard - Elevated Risk

Detailed findings

Cancelled operations - No evidence of risk

Delayed discharges - No evidence of risk

18 week RTT - Elevated Risk

Cancer wards - No evidence of risk

Well-led:

Staff survey - **average**

Sickness rate 2.9 % - **above**

GMC training survey - **below**

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Inadequate	Good	Requires improvement	Inadequate	Inadequate
Maternity and family planning	Requires improvement	Requires improvement	Inadequate	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Good	Good	Good
Outpatients	Requires improvement	Not rated	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and Emergency, and Outpatients.

Accident and emergency

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

Information about the service

The accident and emergency department (A&E) at Northwick Park Hospital provides a 24 hour seven day a week service to the local people of the London Borough of Harrow. The department sees around 85,928 patients a year and is planned to move to a new purpose-built A&E department at Northwick Park Hospital later in 2014.

The A&E department has facilities for assessment, treatment of minor and major injuries, a resuscitation area and a children's A&E service. There is an A&E observation ward for which patients are admitted for up to 24 hours.

Our inspection included three days in the A&E department as part of an announced inspection. During our inspection, we spoke with clinical and nursing leads for the department. We spoke with four members of the medical team (at various levels of seniority), and eight members of the nursing team (at various levels of seniority), including the lead nurse for safeguarding children and adults. We also spoke with seven patients and undertook general observations within all areas of the department. We reviewed the medication administration and patient records for patients in the A&E department.

The A&E department is a member of a regional trauma network, and the hospital also provides hyper-acute stroke services.

Summary of findings

The A&E department at Northwick Park Hospital required improvement in order to protect people from avoidable harm. There were inadequate staffing levels to provide safe care to patients within the major's treatment area. The escalation protocol was inadequate and did not provide a sufficient or measurably safe response.

Northwick Park Hospital was consistently not meeting the four hour A&E waiting time target. The leadership within the A&E department did not ensure that patient experience and flow through the department was assured. The staff we spoke with demonstrated an attitude of commitment, but their morale was low. However, staff took the time to listen to patients and explain to them what was wrong and any treatment required. Patients told us that they had all their questions answered and felt involved in making decisions about their care.

Accident and emergency

Are accident and emergency services safe?

Requires improvement

There were some systems to protect patients and maintain their safety. However, there were inadequate staffing levels to protect patients from avoidable harm within the major's treatment area. Equipment was clean, but we found that some equipment was not maintained to the manufacturer's recommendations. Medication was recorded and stored appropriately with daily checks carried out by qualified staff.

Training records showed that all staff had received mandatory training, including safeguarding vulnerable adults and children. Mental capacity assessments were being undertaken appropriately and staff demonstrated knowledge around the trust's policy and procedures.

Incidents

- The trust reported 41 serious incidents (SI) to both the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (STEIS) relating to the A&E department between December 2012 and January 2014. This included eight serious incidents involving delays in taking handover of care from the ambulance service.
- Between December 2012 and January 2014 the A&E department had the highest number of recorded incidents, which accounted for 32.5% of all trust incidents reported.
- Staff told us that they reported incidents via the hospital internal reporting system, but not all staff who reported incidents received feedback on the outcome and closure of incidents they personally reported.
- Senior nursing staff told us about evidence of learning from incidents. For example, when the ambulance service provided an alert of a patient they were transporting into the A&E department, a specific team was now co-ordinated via the switchboard, with a 'one call' system from the nurse in A&E.
- The department held monthly clinical governance meetings where mortality and morbidity was one item on a regular agenda. Both medical and nursing staff attended these meetings.

Cleanliness, infection control and hygiene

- We observed that patients who were infectious, or who were awaiting test results for confirmation of any infection, were nursed within a side room on the A&E observation ward. Treatment rooms were deep cleaned after any patient with a suspected infection was transferred or discharged.
- The trust's infection rates for C. difficile and MRSA lie within a statistically-acceptable range for the size of the trust.
- We noted that there were hand cleaning stations within all treatment areas; including the paediatric A&E. Hand sanitizers were located at each door entrance and at each individual treatment cubicle.
- We observed ambulance staff remove dirty linen and clean ambulance stretchers within the same area that patients were handed over, and could not see a specific area identified for this.
- We observed on two occasions that ambulance crews had to clean and prepare the A&E trolley prior to transferring their patient. Both trolleys had dirty linen on them from the previous patient.

Environment and equipment

- The A&E department will be re-locating to a new purpose-built area later in 2014. We noted that current cubicles offered limited privacy and dignity, because curtains separating each cubicle were often inadvertently pulled open with passing staff and trolleys. These issues have been taken into account in the new build.
- The resuscitation area was clean and bright. Resuscitation equipment was available and clearly identified, with equipment trolleys following a system that adopted an airway, breathing and circulation management approach within each resuscitation bay. There was also a specific children's resuscitation equipment trolley.
- Treatment cubicles were clean and well equipped with appropriate lighting.
- We noted that a patient who had already been admitted was held in the ambulance handover area due to no cubicles being available. We observed that it was difficult to maintain this patient's privacy due to ambulance crews waiting to handover another patient, and no ability to handover confidential information. The ambulance handover area was inadequate for this purpose.

- We looked at various pieces of equipment across all areas within the A&E department. We found inconsistency with regards to scheduled servicing, with some pieces of equipment being a year out of date from the recommended service. This was identified by the trust's internal service stickers on each piece of equipment.

Medicines

- During our inspection we checked the records and stock of medication, including controlled drugs, and found correct and concise records, with appropriate daily checks carried out by qualified staff permitted to perform this task.
- We looked at patient prescription charts, which were completed and signed by the prescriber, and by the nurse administering the medication.
- We observed on the A&E observation ward that a patient was not at their bedside after requesting medication. A nurse left the required medication (painkillers) on a table at the end of the patient's bed awaiting their return some time later. We spoke with the nurse and a senior manager around the associated risk of this practice.

Records

- We looked at over 15 sets of notes during our inspection. All of the notes we looked at had completed patient observations, with regular re-assessments, which were recorded.
- We observed that patient records in A&E were kept safe and secure. Notes were easily defined between clinical observations and nursing/medical notes.
- Within the patients' A&E records, we saw that risk assessments were undertaken in the department when patients were there for some time (it is recommended by the Royal College of Nursing that if patients are in an area for longer than six hours, a risk assessment for falls and pressure ulcers should be completed).
- Documentation audits were undertaken by the governance department, and results fed back to staff to highlight any actions that needed to be shared across teams.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were knowledgeable about how to support patients who lacked capacity. They were aware of the need to assess whether a patient had a temporary or permanent loss of capacity, and how to support patients in each situation. If there were concerns regarding a patient's capacity, staff ensured that the patient was safe and then undertook a mental capacity assessment.
- According to the A&E mandatory training database, all nursing and medical staff had undertaken training on the Mental Capacity Act.
- We observed nursing and medical staff obtaining consent from patients prior to any care or procedure being carried out.

Safeguarding

- The A&E department had a safeguarding lead within the department, who was knowledgeable and demonstrated underpinning knowledge of both safeguarding children and vulnerable adults.
- Training records showed that all nursing and medical staff had undergone mandatory safeguarding training at an appropriate level.
- All safeguarding concerns were raised through a robust internal reporting system. The concerns were reviewed at a senior level, to ensure that a referral had been made to the local authorities' safeguarding team.
- Staff that we spoke with were aware of how to recognise the signs of abuse, and the reporting procedures in place within their respective areas.

Mandatory training

- We were provided with comprehensive records of mandatory and supplementary training for all nursing and medical staff, with 92% compliance across the multidisciplinary teams.
- Mandatory training was provided in different formats, including face-to-face classroom training and e-learning (e-learning is electronic learning via a computer system), although staff told us that there was limited time allowed to complete e-learning. One member of staff told us that when they asked if they could complete some of their e-learning at home in their own time, this was denied by the trust and no reason was given for this decision.

Management of deteriorating patients

- The A&E department operated a 'track and trigger' alert system, whereby nurses entered the patient's clinical observations into their notes. The system then provided a score which was used to alert clinicians of any deterioration in a patient's condition.

Accident and emergency

- We observed that the A&E department operated a triage system of patients presenting to the department, either by themselves or via ambulance, and were seen in priority order dependent on their condition.
- Patients arriving as a priority call (blue light) were transferred immediately through to the resuscitation area. Such calls were phoned through in advance (pre-alert), so that an appropriate team were alerted and prepared for their arrival.
- We looked at two pre-alert forms, with regards to pre-alerts that occurred during our inspection, and found that the forms had been completed fully, with patient clinical observations recorded, estimated time of arrival of the ambulance to the A&E department, and the named staff member who took the details over the telephone from the ambulance service.

Nursing staffing

- Information provided by the trust indicated that nurse staffing for the A&E department was not operating at the required whole time equivalents (WTE), with a number of qualified nursing posts vacant. Senior staff told us that they were looking at the Royal College of Nursing's policy to determine whether their current staffing reflected it.
- The A&E department had sufficient WTE of nurses with specific paediatric qualifications working within the paediatric A&E. When they were on duty, they were assigned to the paediatric service within A&E, and would be supported with appropriately trained nurses at all times. In order to ensure that they utilised these skills, staff rotated between all areas within the A&E departments at both Northwick Park Hospital and Central Middlesex Hospital.
- We observed that there was a professional handover of care by staff between each shift.
- All bank and agency staff received a local induction prior to starting their shift.

Medical staffing

- The A&E department had six WTE consultants during our inspection. They were present in the department from 8am until 10pm. There were middle grade and junior doctors on duty overnight, with an on-call consultant system in operation.
- There was a high use of locum middle grade doctors, and the senior management team were aware of this. This was particularly true at weekends and out of hours. The doctor's rota showed that the locum middle grade doctor use was inconsistent. This meant that the hospital was not using the same doctors who had received the trust induction programme and were familiar with the department and protocols.
- The A&E department had a vacancy for a clinical lead and was, at the time of our inspection, recruiting to the post. There was no clinical director for the A&E department at Northwick Park Hospital.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Policies and protocols were underpinned by the appropriate national guidance. Regular comfort rounds were undertaken to ensure that a patient's basic needs were met. We saw that good multidisciplinary working was in place. The trust is currently above the national rate for readmissions to the A&E department. We are not confident that we are currently collecting sufficient evidence to rate effectiveness for accident and emergency.

Evidence-based care and treatment

- Departmental policies were easily accessible, which staff were aware of and reported they used. There were a range of protocols available which were specific to the A&E department. Further trust guidelines and policies were also applicable within the A&E department, such as sepsis and needle stick injury procedures. We noted that treatment plans for patients were based on the National Institute for Health and Care Excellence (NICE) guidelines.
- We found references to the College of Emergency Medicine (CEM) standards, and spoke with medical staff who demonstrated knowledge of these standards.

Care plans and pathway

- There were clear protocols for staff to follow with regards to the management of stroke, fractured neck of femur, and sepsis. The department had introduced the 'Sepsis Six' interventions to treat patients. 'Sepsis Six' is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis.
- Nurses at the A&E department at Northwick Park Hospital no longer obtained blood cultures from

patients who were suspected to be septic, as this was now done by medical staff. A consultant told us that this had not resulted in any significant delay in patients receiving antibiotics who may be suffering from sepsis.

Nutrition and hydration

- The department undertook regular food and drink rounds 24 hours a day, seven days a week.
- We observed catering staff within the A&E department offering breakfast to patients who had been in the department overnight. However, the communication from the catering staff was very limited towards patients, and not all patients were offered breakfast despite being able to eat.

Patient outcomes

- Although we were informed that the department took part in national CEM audits, they were unable to provide us with the results of these, or with evidence that they had used the results to assess the effectiveness of the department.
- The CEM recommends that the unplanned re-admittance rate within seven days for A&E should be between 1-5%. The national average for England is around 7%. The trust had not consistently performed well against unplanned re-admittance since January 2013. Their rate in December 2013 was 11%. This information was not broken down for each individual A&E department.

Competent staff

- 98% of annual appraisals of both medical and nursing staff were undertaken. Staff spoke positively about the process and stated that it was of benefit.
- We saw records that demonstrated 100% of both medical and nursing staff had attended update training in basic, intermediate and advanced life support.

Multidisciplinary team working

- We witnessed comprehensive multidisciplinary team (MDT) working within the A&E department. Medical and nursing handovers were undertaken separately. Nursing handovers occurred twice a day, and staffing for the shifts was discussed, as well as any high risk patients or potential issues. Medical handovers occurred twice a day and were led by a consultant.
- There was a clear professional conjoined working relationship between the A&E department and other allied healthcare professionals within other departments. An example of this was the Short Term Acute Rehabilitation and Re-enablement Service (STARRS). The STARRS service consisted of therapists and nurses who visited the A&E department daily to provide intervention from community services, enabling patients to be discharged home with an appropriate care package and support.
- Staff we spoke with were aware of the protocols to follow and key contacts within external teams. We witnessed staff being professional towards patients during their transition from the care of the ambulance service to the A&E staff.
- The hospital's psychiatric and alcohol team could be accessed to support appropriate patients. Although the department did not collect data with regards to their input, the service was available when required.

Seven-day services

- There was a consultant out-of-hour's service provided via an on-call system.
- The A&E department offered all services, where required, seven days a week.
- We were told by senior staff within the A&E department that external support services were limited out of hours, and it often proved difficult to access them at weekends. This had a negative effect on patient discharges and care packages.

Are accident and emergency services caring?

Good

There was sufficient assurance that the A&E department at Northwick Park Hospital was providing a caring service. We witnessed many episodes of caring interactions between staff and patients during our visit, and feedback from patients and relatives during our visit was universally positive.

The department had worked hard to increase the Friends and Family Test (FFT) response rate. However, during our inspection we did find FFT questionnaires out of view within the ambulance triage and reception areas.

Compassionate care

- We witnessed multiple episodes of patient and staff interaction, during which staff demonstrated caring and compassionate attitudes towards patients.

Accident and emergency

- The trust was performing significantly worse than the England average in the NHS Friends and Family Test within the A&E department in January and February 2014.
- Staff were knowledgeable about the care pathways available to benefit their patients.

Patient involvement in care

- Patients told us they felt informed about their patient journey, and that staff were responsive to their needs. They told us that staff dealt with their needs quickly, and were polite when speaking to them. We observed staff explaining to patients if there was going to be a delay in seeing a doctor, what the reason for that delay was, and how long they would have to wait to be seen.
- Patients and relatives said that they would recommend the service to family and friends.
- The department arranged the nursing staff into teams that looked after specific areas, which facilitated a better patient experience, by having a named nurse looking after them whilst in the accident and emergency department.

Emotional support

- We observed staff providing patients and relatives with emotional support when appropriate.

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

(for example, to feedback?)

Requires improvement

The A&E department requires improvement in coping with surges of activity which occur on a regular and potentially anticipatory basis. The escalation protocol was inadequate and does not provide a sufficient or measurably safe response, as evidenced by patients waiting for more than 15 minutes within the ambulance triage area before being handed over to A&E staff. There were regular occurrences of ambulances 'stacking' within the department, delaying the ambulance handover.

Trusts in England were tasked by the government with admitting, transferring or discharging 95% of patients within four hours of their arrival in the A&E department. The North West London Hospitals NHS Trust was consistently not meeting this target. The trust has struggled to maintain the 95% target, and many times has been below the England average for the period from October 2012 to May 2013. However, since May 2013, the trust waiting times have improved to closer to the England average and the 95% target. The lowest was 84% in April 2013.

Service planning and delivery to meet the needs of local people

- The A&E department had an escalation policy which was developed by the management team.
- The trust has planned to build a new A&E department in order to meet the needs of patients once the unit at Central Middlesex Hospital closed. This new department opens in late 2014.
- The A&E department at Northwick Park Hospital provided a relatives room and we found that this room was inadequate for its purpose. There was a lack of any appropriate information in the room, and it was not located in a suitable place. The room had windows that overlooked the ambulance entrance, with ambulance crews bringing patients into the A&E department, with the possibility that some patients may be in a critical condition.

Access and flow

- During periods of high demand, the A&E department struggled, and it was not clear how the co-ordination within teams would achieve a better patient experience and flow through the department. We noticed ambulance handovers and speciality reviews being delayed. In particular, there were delays in medical patients waiting to be seen.
- The trust was rated within expectations with regards to transition from the ambulance to the A&E department. However, there was a significant contributing factor with regards to proactive bed management that inhibits patient flow and causes consistent ambulance handover delays.
- The trust has struggled to maintain the 95% A&E waiting times target, and many times has been below the England average. The lowest was 84% in April 2013.
- The trust can be seen to be performing worse than the England average for the percentage of emergency admissions via the A&E department waiting 4-12 hours from the decision to admit until being admitted. In February 2014, the trust was performing at 15%, with the England average being 6%.
- The national average for percentage of patients who leave A&E departments before being seen (recognised

by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of time they are having to wait) was between 2-3% (December 2012 – November 2013). The trust's A&E departments were at 2% in November 2013, with the highest percentage being 2.5% in April 2013.
- Senior staff within the department knew who should be contacted when there were delays to patient flow. There was an internal 'live' electronic system of monitoring to evaluate and manage the effectiveness of patient flow to assist with bed demand.

Meeting people's individual needs

- A translation telephone service was available, so that patients who were unable to speak English were able to communicate with staff. Within the department, it was possible to request a translator, though staff admitted that they would rarely do this. The staff had a wide multicultural background in line with the population that the hospital serves, and they told us that they would therefore usually use other staff members as translators.
- There were multiple information leaflets available for many different minor injuries. These were available in all of the main languages spoken in the local community.
- The department had designated 'champions' who led on specific areas to facilitate people's individual needs. For example, there were 'champions' for learning disabilities, mental capacity and dementia.

Learning from complaints and concerns

- The A&E department promoted the Patient Advice and Liaison Service (PALS) which was available in the hospital. Information was available for patients on how to make a complaint and how to access the service.
- All concerns raised were investigated by staff, and there was a centralised recording tool in place to identify any trends emerging.
- We were told that learning from complaints was not disseminated to the whole team in order to improve the patient experience within the department. Root cause analyses of complaints were not carried out and we were told that this was due to there being so many complaints, that it caused 'complacency' amongst staff.

Are accident and emergency services well-led?

Requires improvement

The leadership within the A&E department was insufficiently matured to ensure that patient experience and flow through the department was assured. Universally, throughout the department there was an acceptance of impending change, but staff were apprehensive about the forthcoming new A&E department. The staff we spoke with demonstrated an attitude of commitment, but their morale was low.

Vision and strategy for this service

- The future vision of the A&E department was not embedded within the team, and was not well described by all members of staff.
- The trust had a lack of vision in the promotion of the STARRS service. The service was driven from within the A&E department, and not at trust level to further avoid admissions and promote discharges with incorporated care plans.
- Not all staff were knowledgeable about the trust's vision and journey. This was despite information being available to all staff, in different formats, about the trust's vision and strategy, and staff being aware of how to access it.
- Staff were aware of the priorities for the department, and were provided with updates on any changes to the department's priorities and its performance against those priorities.

Governance, risk management and quality measurement

- Monthly departmental meetings were held. We were provided with the minutes of the meetings held over the past six months. Top risks were discussed, including what was being done to mitigate the risks.
- A quality dashboard was available within the A&E department. However, it was displayed in a back corridor and had no information displayed on the board. We spoke with staff about quality indicators and there was a lack of demonstrable knowledge about it.

Leadership of service

- There was a strong departmental team, which was respected and led by the senior nurses.
- The senior management team were interviewed separately, and the conclusion drawn from the

interviews was that the leaders' visions were not cohesive and, at the time of the inspection, there was a lack of joint ownership of the issues faced by the department.

Culture within the service

- The high percentage of locum use contributed to the lack of cohesive working, with the potential to impact on the culture within the service. The vacancies within the middle grade doctor team resulted in an onerous rota, which was potentially unsustainable and had a negative effect in supporting junior doctors.

Innovation, learning and improvement

- We were told that nurse teams had an away day every six months, which included all grades of nurses. This facilitated update training and a forum to discuss relevant topics.

Medical care (including older people's care)

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

Information about the service

Medical care at Northwick Park Hospital was overseen by a number of directorates, such as elderly care and stroke, and specialist medicine. As part of the inspection we visited eight wards across a range of medical specialities, including elderly care, the stroke unit, cardiology and general medical wards. We also visited the acute admissions unit (AAU), the short stay acute unit (SSAU) and the coronary care unit (CCU).

We spoke with 32 patients and relatives, and 41 staff across all disciplines. We observed medical and nursing handovers, a ward round, a multidisciplinary team meeting, and attended a bed management meeting. We also looked at 17 patient records and tracked the pathways of care for four patients.

Summary of findings

Care and treatment in the medical services were based on published guidance, and there was evidence that outcomes for patients were good. Safe staffing levels had been set and were maintained by the use of bank and agency staff. Patients we spoke with told us they had been treated with dignity, shown respect and had been well cared for by staff. We found that there was strong and enthusiastic leadership shown by directorate management teams, including matrons and ward managers. The environment and equipment were visibly clean, and infection control practices were good.

Care was organised to meet the needs of the patient, and translation services were available. There was a multidisciplinary approach involving patients and relatives, to ensure the safe and effective discharge from hospital.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

The safety of medical care services at Northwick Park Hospital requires improvement. Training rates among medical staff were poor. The constant pressure for beds at the trust had contributed to an additional workload for the on-call medical team, particularly at night. There was poor handover between medical staff working daytime hours and those working nights. Medical and nursing staffing levels and skill-mix had been assessed, and there was sufficient planning to maintain safe levels and mitigate risks. The environment and equipment were visibly clean and infection control practices were good. Patients' discharges in some boroughs of London were delayed sometimes for long periods of time. Staff knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards was variable.

Incidents

- The trust had been identified as a low reporter of incidents to the National Reporting and Learning System (NRLS). Medical specialities accounted for 47 incident reports, the majority (30) were rated as moderate harm, 12 as abuse, four as severe and one death.
- The trust used an electronic incident reporting system to report incidents. Staff described this system as 'cumbersome'; however, they were knowledgeable about the types and categories of incidents.
- Nursing and allied health professional staff confirmed that they were encouraged to report any incidents, and saw it as a positive way to drive learning and improvement for patients and practice.
- Staff gave us a demonstration of the process followed to report an incident, and provided examples of changes in practice. On one ward, following a patient transferring in with an undisclosed pressure ulcer, a full documented check of the patient's pressure areas with the accompanying nurse had been implemented.
- Medical staff told us that they were 'disillusioned' with the electronic incident reporting system, as they did not receive a response after they had used it to report incidents. We were told that a number of trust grade doctors (clinical fellows/locums) did not have access to the system, and were not aware of how to report incidents.
- However, other staff members reported that they received feedback after reporting incidents, from the ward managers or matrons, and in some cases, the manager of the electronic incident reporting system. A number of staff told us that in the week prior to the inspection that they had started to receive an acknowledgement email, informing them that the incident was being investigated, and the name of the person who was carrying this out.
- Matrons confirmed that incidents were discussed with managers at directorate and nursing meetings. The matrons were also required to submit a monthly quality report to the director of nursing.
- Consultants told us that mortality and morbidity meetings were held in some specialities, but not all. These meetings did not always consist of a junior doctor.

Safety thermometer

- The trust monitored safety thermometer indicators, and produced monthly local key performance indicator (KPI) reports which were prominently displayed on all wards. Staff were aware of the ward results, and told us they were discussed in ward handover meetings.
- Information provided by the trust showed that pressure ulcer incidence was below the national average overall. This is a positive result. For patients over 70 years of age the trust had performed below the national average. Local results seen on the wards confirmed the low incidents of hospital-acquired pressure ulcers, and staff were proud of their record.
- For all patients suffering from new venous thromboembolisms (VTE's) the trust performed below the England average for six months out of the last 12 months, again this is positive. Patient records seen showed the majority of patients had been assessed for VTE on admission.
- For patients suffering new urinary tract infections (UTI's) the trust performed below the England average for seven months out of 12. This means that the trust was experiencing less UTI's than the England average.

- For patients suffering falls with harm, the trust performed below the England average for five months out of 12. However, the trust was above average in March and May 2013.

Cleanliness, infection control and hygiene

- The trust reported infection rates for C. difficile and MRSA that were within the statistically acceptable range for the size of the trust.
- There were infection prevention and control policies available on the trust intranet, and staff reported they could access them.
- We observed that staff complied with the trust uniform policy and demonstrated good practice in following hand hygiene protocols. Staff also complied with 'bare below the elbow' guidance, and adequate supplies of personal protective equipment (PPE) (gloves, aprons, etc.) were available and used appropriately.
- Hand sanitising points were seen outside wards and departments, and staff and relatives were observed using them before entering. Hand basins were stocked with soap and disposable towels, and hand washing guidance was displayed.
- Hand hygiene audits were carried out monthly and formed part of the nursing KPI report. Three of the eight wards we visited had not achieved the required 90% benchmark in April 2014. However, all wards had an action plan in place to address the identified issues before the next audit.
- Matrons and ward managers conducted monthly environmental cleanliness audits with the contracted cleaning company. We saw samples of the cleaning audit results on the wards, and the compliance rates were over 90%.
- All wards had side rooms and staff confirmed that these were used to isolate patients with infections. Signage was displayed on the doors of side rooms, to show the precautions that staff and visitors were required to take before entering the room, and how to dispose of PPE before leaving the room.
- The patient-led assessment of the care environment (PLACE) in 2013 had scored the hospital 98.8% for cleanliness, which was above the benchmark target of 95.7%.

Environment and equipment

- Wards visited were, in the main, uncluttered, and staff and patients had sufficient room to move around unhindered so that care could be delivered safely.
- Staff reported that there was a lack of storage space and rooms for private conversations in some wards.
- Resuscitation equipment was available in all wards, and records showed that it was checked daily as part of the ward's routine safety checks.
- Equipment was clean and well maintained. Broken equipment was labelled and removed from use, and staff told us that they had to get approval before contacting the manufacturer to arrange repair.
- The hospital's PLACE score was lower than the benchmarks for the condition, appearance and maintenance of its premises.

Medicines

- Medicines were well managed in the wards. Clinical rooms were locked, and coded locks allowed staff restricted access. Drug trolleys and cupboards were locked, and intravenous fluids were stored safely in lockable cupboards.
- The nursing KPI report for April showed that the elderly and stroke wards had achieved 100% compliance with daily controlled drug checks.
- Staff wore red disposable tabards when carrying out the drug round. Staff told us that this was to denote that they were not to be distracted whilst dispensing medication. However, we observed several occasions across the wards where the dispensing nurse was interrupted by colleagues.
- Patients reported that they received their medication as prescribed.

Records

- We looked at 21 sets of patient records during the inspection. Records were completed by all members of the multidisciplinary team. Nursing risk assessments and point of care records were available at the bedside, and were completed contemporaneously. We found that the standard of record keeping was, in the main, good and adhered to professional standards.
- Every patient was assessed on admission for a range of potential risks including malnutrition, moving and handling, falls, and risk of developing pressure ulcers. We also saw evidence of reviews of patient care, either when the patient's condition changed, or on a weekly basis regardless.
- We saw 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms in 10 patient records. They were completed in full, signed by the consultant, had review

dates, and there was a record of the discussion with relatives/carers. The forms were filed in the front of the patient record, and were coloured green so that they were easily identifiable.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We heard staff ask patients for their permission before administering care to them.
- Staff knowledge of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) was limited, despite some stating that it was covered as part of mandatory training. We were told that they expected the doctors to carry out MCA assessments.
- Staff were aware of best interest meetings being held, particularly for patients with dementia.
- Staff reported that they could contact the psychiatric liaison team to carry out assessments when appropriate.
- There was no evidence provided which showed that the trust had made any applications in respect of DoLs.

Safeguarding

- There were processes in place for staff to refer safeguarding concerns.
- The trust safeguarding lead was the deputy director of nursing, and for each directorate there was a nominated lead, which was usually the head of nursing.
- Staff told us they would report concerns to the matron or head of nursing. Out of hours, the site practitioner would be contacted.
- Staff confirmed that they attended safeguarding training, which was part of the mandatory training annual updates. Data provided by the trust showed that over 78% of staff in medical services had completed safeguarding of vulnerable adults, and safeguarding children, training.
- Safeguarding of Vulnerable Adults (SOVA) Board meetings were attended by the safeguarding leads for medical services. Minutes provided showed that they were held quarterly, with representatives from the local authority.
- The trust had implemented the use of health passports for patients with learning difficulties, and we were informed that these patients could be flagged on the patient administration system.

Mandatory training

- Data provided by the trust showed that mandatory training rates ranged from 66% to 72% in medical services. Across the trust, the training rates for staff groups ranged from 77% for nurses, to 79% for allied health professionals (AHP's). Medical staff attendance was the second lowest reported rate, of 41%.
- Staff attendance at mandatory training was monitored, and managed by individual managers, and the ward e-rostering system alerted managers to when staff required an update.

Management of deteriorating patients

- The national early warning score (NEWS) tool was used routinely to identify deteriorating patients. There were clear escalation instructions accompanying the observation charts, and an escalation policy was available to staff for reference. The nursing KPI report for April 2014 showed that the NEWS snapshot review had a benchmark of 100%, which was not achieved by all wards.
- The majority of NEWS charts we saw were completed, and trigger scores had been escalated. However, in our review of the point of care observation records on CCU, we saw four patients, all of whom had scores recorded which should have triggered an escalation response, but staff had not done so.
- There was an outreach team available to support staff in managing deteriorating patients.
- On wards where patient acuity meant that they were at greater risk of a deterioration of their condition, appropriate monitoring equipment was used to manage and support patients.

Nursing staffing

- We were provided with details of the acuity tool used to set safe staffing levels in clinical areas. Staff reported that a review was carried out annually, and there had been an increase in some staffing levels as a result.
- On the older people wards, ward managers were supernumerary, and this enabled them to supervise, monitor and support staff. We noted this had not been achieved across all medical wards, but where it had not, they were working towards it.
- We observed that there were sufficient staff on duty to meet the needs of patients at the time of the inspection. The trust employed bank nurses, who attended trust induction, and agency staff told us that they were shown around the ward at the start of a shift.

Medical care (including older people's care)

- We observed a ward handover at night which was in several stages, with the whole team in the office, followed by the 'bedside with patient' involvement. We also saw 'ward board' handover meetings between MDT members at various points during the day.
- Ward managers told us that they had a funded staffing establishment for their wards, and were very aware of the number of vacancies. Recruitment to nursing posts was a recognised challenge for the trust. There was an active ongoing recruitment programme, with some nursing staff being recruited from across Europe and further afield.
- Quality boards displayed the funded numbers of registered nurses and healthcare assistants that should be on duty against the actual number. We saw staffing numbers adjusted to meet the needs of patients, with additional staff brought in to provide one-to-one care when this was needed.

Medical staffing

- There were a variety of specialist consultant teams across the medical services at the hospital, each with a team of doctors. There was evidence of a large proportion of locum or trust employed doctors, known as clinical fellows, to support patient treatment where junior doctor training posts had been discontinued by the Deanery.
- There were two junior doctors providing medical cover out of hours and at weekends, supported by specialist grade registrars, one of whom was based in the AAU. Doctors reported that the workload was very heavy, with medical patients outlying in most wards throughout the hospital.
- Comprehensive medical handovers were held on the AAU between doctors on normal working hours and the on-call medical staff using the telescreen patient board. We were informed that there was no specific or recorded handover for medical patients. We were also told that ward-based staff would ring a set bleep number to request the medical team to see patients, which added to their already heavy workload.
- Consultant wards rounds took place in most wards on a planned basis. On the AAU there was a dedicated rota of 24 hour on-call consultant cover responsible for reviewing all patients admitted in the previous 24 hours, and making decisions about the patient's ongoing care and treatment.
- Ward rounds and 'ward board' rounds took place regularly throughout the day amongst the MDTs.

Major incident awareness and training

- The trust had opened additional beds to meet the winter pressure of increasing numbers of patients. In total, we were told that 25 additional beds were opened, 10 on a ward for older people, and a 15 bed ward (Byrd) was re-established as a medical ward.
- Byrd Ward had a consultant on site during day time working, supported by two junior doctors, to support patient treatment and facilitate a rapid response and discharge. The length of stay was, on average, three days. Out of hours, Byrd Ward was covered by the on-call team.
- The trust was planning to open an additional 100 beds to mitigate bed closures at another site, and to address the potential winter pressures ahead. Directorate managers were in the process of making business cases to the trust executives with their plans to address the issue. However at the time of the inspection there was no definitive plan in place for when the A&E closed at Central Middlesex Hospital.

Are medical care services effective?

Good

Medical care services were caring. Although the trust was performing below the national average in the Friends and Family Test (FFT), local results showed that the trend was improving in medical care services.

Over the period of our inspection we witnessed many episodes of kind, compassionate and caring interactions from all staff groups. Patients and relatives were positive in their feedback about the care they received. Patients commented favourably about staff working in the medical wards, and they told us that staff were "kind and caring" and "enthusiastic".

Compassionate care

- The overall trust response rate (24.8%) and score of 65 for the FFT was just below the national average; however, data provided showed this was an improving trend. Individual ward scores were prominently displayed on all wards.

Medical care (including older people's care)

- In the inpatient survey 2013, out of a total of 60 questions, the trust performed the same as other trusts in 53 questions and worse than other trusts in seven questions.
- The cancer patient experience survey was designed to monitor national progress on cancer care across 13 different cancer groups. Of the 69 questions for which the trust had a sufficient number of respondents on which to base the findings, the trust was rated by patients as being in the bottom 20% of all trusts nationally for 35 of the 69 questions.
- Patients commented favourably about staff working in the medical wards. We were told that staff were "kind and caring" and "enthusiastic".
- Patients fed back that they were positive about the care and treatment that they received. One patient approached us and told us to "give gold stars to everyone as they were absolute marvels".
- There was consistent use of red 'do not enter' signs attached to closed curtains when delivering personal care in order to preserve patients' dignity. Staff were seen to request permission to enter closed curtains.
- Staff interaction with patients, relatives and between themselves were professional, calm and demonstrated respect.
- The hospital's PLACE score in 2013 was lower than the benchmarks for patient privacy. This shows that the patient's privacy was respected.

Patient understanding and involvement

- Patients were allocated a named nurse on each shift. We witnessed staff introducing themselves to patients, and there was a bedside handover with patient involvement.
- Matrons visited the wards daily and talked with patients and staff in order to pick up safety or quality concerns. Patients reported that senior staff were usually very approachable and responsive to their comments.

Emotional support

- Senior nurses on the older peoples' wards and stroke unit told us that patients had access to counselling services.
- There was professional clinical psychology support available to patients following a stroke.
- The trust had a range of clinical nurse specialists available to support patients and staff, including in palliative care, endocrinology and respiratory care.
- There were arrangements in place to refer patients for psychiatric and psychological support when required.

Are medical care services caring?

Good

Medical care services were responsive to the needs of patients and others. The trust had very high bed occupancy rates, and there was constant pressure to identify beds. Buddy wards had been established to accommodate medical outliers, but on occasions the high numbers of outlying patients prevented this arrangement from being implemented.

Care was organised to meet the needs of the patient, and translation services were available. There was a multidisciplinary approach, involving patients and relatives, to ensure the safe and effective discharge from hospital.

Service planning and delivery to meet the needs of local people

- Care bundles had been developed to use when patients were at risk of triggering a safety thermometer metric, to ensure that appropriate assessments, care and preventative measures were undertaken.

Access and flow

- The trust told us that bed occupancy was very high, running at levels of 96-98% against a national average of 85.9%. It was generally accepted that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital (Dr Foster Intelligence).
- The majority of medical patients were admitted through A&E via the AAU and SSAU. This meant that patients were admitted to a short stay ward when they potentially required a longer period of stay. Patients who suffered a stroke were reviewed and transferred to the stroke unit for thrombolysis. The unit had been recognised as having the best response times in London.
- Data provided by the trust showed that between 1 January and 20 May 2014, the numbers of medical outliers on surgical wards ranged between 8 and 43 patients.
- The trust had set up buddy arrangements between medical and surgical wards, with patients from the respective specialties accommodated on their buddy

ward. Staff told us that the high number of admissions did not always allow the arrangement to work effectively, and therefore patients were allocated to any available bed or remained in AAU.
- The trust had established the STARRS team, to co-ordinate and provide support to discharge patients safely. Discharge arrangements were documented in multidisciplinary patient care plans. One patient did raise concerns about their previous discharge, and the lack of information and follow up provided following admission for a cardiac problem.
- The trust had an established discharge lounge to accommodate patients who were ready for discharge and waiting for transport within a 180 minute timescale. This allowed beds to be vacated earlier and allowed more timely transfers across wards.
- A number of patients told us that they were moved "during the night" in order to "free up a bed".

Meeting people's individual needs

- The trust employed a multi-ethnic workforce, who spoke a wide range of languages. They were utilised as translators when required. Staff confirmed that they could also arrange for translators to support patients and relatives during consultations, and gave us the name of the company which provided this service.
- Health passports were used to facilitate the individual care of patients with learning disabilities. Information provided by the trust suggested that the passports would also be used to support vulnerable patients with dementia.
- Dementia care was supported by a recently-appointed dementia matron. There was a dementia care bundle (checklist) to help staff assess the care needs of patients more accurately.
- Patients at risk of falls, or who required one-to-one care, were supported by additional staff.

Learning from complaints and concerns

- The trust had signs displayed across its premises advising people on how to raise concerns, and these included the contact details of the chief executive.
- Leaflets and posters advertising the Patient Advice and Liaison Service (PALS) were seen in all areas.
- The trust used 'patient stories' to aid learning and improve the patient experience across the wards.
- Matrons and ward managers told us that they carried out daily ward rounds to pick up issues and manage them in a timely way.
- The nursing KPIs recorded the number of PALS issues or complaints across the medical wards.
- Directorate managers provided information to show that the number of complaints had decreased, despite a spike during December 2013 and January 2014. The main theme of complaints was related to discharge, particularly patient choice of where they were to be discharged, but this was usually dictated by the financial parameters of the local authority and clinical commissioning group (CCG).

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Are medical care services well-led?

Good

We observed good local leadership across medical care services. Staff talked positively about their role, and told us that they felt supported by local leaders. They felt that the directorate managers were supportive and responsive. They also recognised that the senior executive team were taking positive action to improve facilities and the working environment for staff, as well as to improve the patient experiences of care.

Vision and strategy for this service

- Senior staff were more aware of the trust strategy and vision than junior staff. However, each ward had a ward philosophy displayed that had been developed by the ward team. The statements supported caring and compassionate care for patients by staff.
- All staff were aware of the future merger arrangements for the trust, and the development of new facilities in A&E.

Medical care (including older people's care)

Governance, risk management and quality measurement

- We saw information boards containing governance data to inform patients, staff and visitors of the clinical audit results month-on-month.
- Risks were identified, and a directorate risk register was maintained and updated regularly by senior managers. The highest risks identified were related to staffing issues and the repair of premises.
- The trust had taken action to address a previous lack of investment in the governance infrastructure, and had started to recruit staff and install technology to improve their performance. In older peoples' care and stroke services a governance lead had recently been appointed.
- Junior doctors in medicine jobs told us that they received little to no information about governance in their team, and were unable to attend meetings due to their workload.

Leadership of service

- We saw good local leadership on medical wards, from ward managers supported by matrons and heads of nursing.
- The older people and stroke directorate were leading by example, and all ward managers were supervisory to provide leadership and support for staff. The other medical directorates were working towards this standard.
- Staff told us that the senior management team in the older people and stroke directorate were visible and known to staff. The general managers were not as well known or visible in other directorates.
- There were pictorial trust board posters displayed across the trust. Most staff were aware of the chief executive and medical director. There was evidence that executives made quality visits to wards and reported on their findings.
- The trust was rated as better than expected or tending towards better than expected for 10 of the 28 NHS 2013 staff survey key findings. Areas where staff felt that the trust performed well were satisfaction with the quality of work and ability to deliver patient care, work related stress, reporting errors, near misses or incidents, pressure to attend work when feeling unwell, good communication with senior managers, ability to contribute towards improvement at work and motivation at work.
- The trust was rated as worse than expected or tending towards worse than expected for 12 of the 28 NHS 2013 staff survey key findings. Issues included support from immediate managers, appraisals, discrimination and equal opportunities for staff, as well as staff witnessing potential errors and near misses.

Culture within the service

- The trust encouraged staff members to report patient safety concerns.
- Staff we spoke with were proud to work for the trust, and a high number had worked for the trust for a long time. They described the culture of the organisation as friendly and supportive.
- Feedback and learning from incidents and complaints was not embedded across medical services. Staff told us they did not always receive feedback when they had reported an incident.

Public and staff engagement

- Staff told us they were sent daily emails and the chief executive's bulletin in order to update them on trust developments.
- Various staff groups reported that they had attended open forum meetings with the chief executive, and that the management of the trust were approachable and responsive.
- Staff also told us that they were kept up to date with information through the intranet and via staff meetings in their ward/department.

Innovation, improvement and sustainability

- The stroke unit was providing a 'gold standard service' with seven day working. It had been the recipient of the prize for the 2013 Clinical Leadership Team at the British Medical Journal awards.
- The trust supported dementia care with the appointment of a dementia matron.
- Supervisory ward managers were established in older peoples' care.
- The trust showed commitment to safe staffing levels with regular acuity reviews to ensure patient safety.

Surgery

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

Information about the service

Northwick Park Hospital has facilities for both emergency and elective surgery. It has nine functioning operating theatres. Patients undergoing surgery are admitted to wards with medical patients. The department consists of a day case assessment unit, a surgical assessment unit, theatres and a recovery suite. At the time of the inspection, relatively few elective general surgery procedures were taking place at the hospital.

Summary of findings

The surgical service at Northwick Park Hospital requires improvement. Whilst the day-to-day running of the department generally provided safe care, the service faced notable risks. The low number of middle grade doctors and the low number of general surgical lists meant that there were delays in emergency surgery taking place. Nursing staff received appropriate training and support, and multidisciplinary working was good. However, there was a lack of up-to-date protocols and guidelines for staff to work from. Patients said that they were well looked after and supported, and we observed this taking place.

Whilst the concerns highlighted had been raised internally and plans to improve the department had been drawn up, these changes had not occurred. It was not clear if there was a specific plan for when these planned adjustments would be made.

Surgery

Are surgery services safe?

Requires improvement

The surgical service learnt from incidents and accidents. There were appropriate ongoing checks on the safety of the service. Departmental policies and procedures were suitable for keeping patients safe. However, low numbers of medical staff placed considerable pressure on the department. In addition, due to a lack of dedicated general surgical space within the hospital, general surgical patients were placed on a range of wards where, on occasions, suitable staff were not available to treat them.

Incidents

- Between December 2012 and January 2014 four 'never events' took place at the trust. ('Never events' are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.) All four of these related to surgical services.
- Staff were able to describe changes that had been made to the way in which they worked as a result of the review of incidents. We saw records of multidisciplinary committee meetings where incidents were discussed, including their causes and how they would be prevented in the future.
- In addition, the department reported 35 incidents to the National Reporting and Learning System (NRLS). Of these, 24 were classified as 'moderate', three as 'abuse', four as 'severe' and four were deaths.
- Staff were aware of how to escalate incidents within the ward using an electronic incident reporting system.

Safety thermometer

- The department used a safety thermometer to monitor the safety of the services it was providing. The performance of the department between April 2013 and March 2014 was rated positively at 98.35% harm-free. Results were collected for each ward so that isolated episodes of poor performance could be highlighted.

Cleanliness, infection control and hygiene

- The department undertook regular audits of the standards of infection control. This included aspects of care such as MRSA screening and hand hygiene. In general, the department was compliant with these standards, and the results were presented in a manner that would enable staff to address isolated issues that arose.
- During our inspection we visited all of the surgical areas of the hospital. All areas that we saw were clean and tidy. Hand washing facilities, sinks and personal protective equipment were available throughout.

Environment and equipment

- Appropriate emergency drugs and equipment were available throughout the department. Regular checks were made on these to ensure that they were in date and in good working order.

Medicines

- All medicines were stored in a secure fashion that was accessible only to staff. Records were kept of what medicines had been administered.

Records

- We reviewed numerous patient records across the department. All of the records we reviewed showed that basic information and risks assessments were appropriately completed. Patient observations were up to date. Details of daily MDT notes were included, as was discharge data. A recent audit of records showed that this consistent level of completion had been sustained over time.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received mandatory training in Consent, the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.
- There were specific forms to be completed when a person was unable to consent to surgery that indicated the reasons that this was the case.
- Departmental staff reported that if they had concerns about someone's capacity to make decisions they would involve other professionals and the patient's family, as appropriate. Medical staff would undertake any mental capacity assessments.
- In the records we reviewed, patients' consent to surgery was appropriately completed.

Safeguarding

- There was a safeguarding policy and procedure in place.

- Staff received mandatory training in safeguarding vulnerable adults, though take-up of this training was variable across the department.
- There was an internal trust safeguarding team to whom staff could report their concerns.
- We spoke to staff across the trust who were able to described signs of possible abuse, and the actions they would take if they had any concerns.

Mandatory training

- The trust kept a record of mandatory training completed by staff within the surgical department. Whilst a satisfactory range of topics were covered, including basic life support and infection control, the information provided showed very variable rates of completion of this training across the department.
- It was noted that whilst some staff had received basic life support training, not all relevant staff had been trained to use the defibrillators on the resuscitation trolleys.

Management of deteriorating patients

- At the time of the inspection general surgery only had six elective lists per week. There was only one National Confidential Enquiry into Patient Outcome and Death (NCEPOD) list during week days and two NCEPOD lists at the weekend. Given the volume of patients attending for emergency general surgery (non-trauma), low-risk emergency procedures often needed to be delayed and took place outside of the recommended timeframes as set out in national guidance. Staff considered that this put patients at considerable risk. This had been placed on the department's risk register.
- Staff also reported that on occasions, due to pressure on critical care beds, they had been asked to accept patient transfers before the patient was well enough, which resulted in them subsequently being readmitted to the critical care unit.
- The World Health Organization Surgical Safety Checklist was used by the department to ensure that people were safe prior to, during and after surgery. Recent audits of the completion of this did not highlight any risks within the department.
- The department used an early warning scores system to monitor the ongoing condition of patients. In recent audits most wards scored highly in terms of their use of this tool.

Nursing staffing

- The hospital did not have a dedicated surgical ward. Instead, general surgical patients were admitted to a variety of other specialist wards. Staff reported that large numbers of the nurses on these wards had surgical training or experience. They told us that they tried to admit patients to wards where the nursing staff had the relevant skills to be able to care and treat patients following general surgery. However, they noted that at times, due to a lack of availability of beds, patients had to be admitted to wards where the nursing skill mix was not ideal for treating patients following general surgery, and on some occasions, patients had to be admitted to medical wards. Staff did report however, that they had some scope to move staff with particular skills between wards, and that they got extra support from specialist staff if they needed it. Senior staff described this as an ongoing challenge.
- Senior staff reported that they used the 'Hurst' workforce planning tool, as well as a recently commissioned report by an external company, to decide on the nursing levels and skills mix of nursing staff that they needed on each ward.

Medical staffing

- Surgical cover by medical staff was provided seven days a week.
- Staff reported that there was a lack of junior medical staff since a reduction in the number of trainees following a visit by the Deanery and General Medical Council in 2013. Whilst attempts had been made to mitigate this through the use of nurse practitioners, a second Registered Medical Officer (RMO) on duty, and recruitment of other staff, this was not sufficient to fill the gaps. It was reported that this put great pressure on junior doctors, and could cause delays in discharge, as medical staff were not available to sign for medicines that patients needed to take home with them.
- Staff reported that whilst they had five emergency surgeons, due to the low number of general surgery lists there was not enough emergency theatre space for them to use so gaps in elective lists were used for emergency patients.

Major incident awareness and training

- There was a major incident policy and procedure in place.
- Staff had training in what to do in the event of a major incident and had undertaken simulated exercises.

Surgery

Are surgery services effective?

Requires improvement

There were trust policies and procedures that were followed by staff to ensure that patients received effective treatment. Nursing staff received appropriate training and support, and multidisciplinary working was good. However, there was a lack of up-to-date protocols and guidelines for staff to work from. In addition, due to a lack of available surgical lists, staff were unable to carry out elective general surgery.

Evidence-based care and treatment

- There were a team of consultants who sent out bulletins each month on any new NICE guidelines that had been published. In addition, specialist nurses (such as Tissue Viability Nurses) provided specific guidance to staff on any developments in their field. Clinical developments were discussed at handovers.
- Standard risks assessments were used to evaluate patients, and ensure that they were safe whilst within the department. These included the Waterlow assessment to check for risks of pressure ulcers and the MUST nutritional screening tool. There were also specific assessments, undertaken to ensure that people were fit and well enough to undergo surgery, which followed national guidelines.
- We looked at a wide number of clinical protocols within the department that related specifically to the care and treatment of patients, such as emergency transfer protocols, analgesia guidelines and fluid management. All of these were out of date, and in the case of the post-operative fluid management guidance, contravened more recent guidance. We were concerned that new students and nurses might be referred to these guidance documents to answer any questions that they may have.
- However, we also looked at the operational protocols within the surgical admissions unit that had been opened approximately one year earlier. There were appropriate guidelines for admission, escalation, and the appropriate treatment of specific conditions. Staff reported that the unit had helped to ease the pressure on the hospital's A&E department.
- Staff undertook audits and checks on medical early warning score charts and malnutrition universal screening tool (MUST) charts to ensure that they had been completed appropriately. Staff were able to describe the actions they had taken to improve the completion rate of MUST charts in response to the outcome of one of these audits. They also told us that fluid charts were being redesigned after an audit had found that they were not being completed correctly.

Pain relief

- The trust had a specific pain team that worked across the hospital.
- There were specific policies on pain relief within the trust. Staff reported that post-operative pain was discussed with patients at the pre-operative stage.
- Prescribing nurses had specific assessment tools and guidance that they could use to provide pain relief to patients in the absence of medical staff.

Nutrition and hydration

- Patient records we reviewed showed that nutritional assessments and fluid charts had been correctly completed.

Patient outcomes

- Given the volume of patients attending for emergency general surgery (non-trauma), there was very little capacity for elective surgical procedures to take place. Whilst there were adequate numbers of senior staff who ran clinics at the hospital to carry out procedures, these procedures were often transferred to nearby hospitals. It was not clear whether a patient who was transferred to another hospital within 14 weeks counted as having met the trust's key performance indicator (KPI) of being treated within 14 weeks.
- Since February 2014, very few elective general surgical procedures had been booked at the hospital, which had allowed staff to reduce some of the backlog of procedures that the previous system had generated. Staff reported that whilst senior trust staff had agreed that installing a second NCEPOD list during weekdays would alleviate many aspects of this issue, this had not been forthcoming to date. This matter had been placed on the department's risk register.
- The department participated in the National Bowel Audit. In the last quarter of 2013/14 the trust scored positively in terms of the quality of care and treatment they provided. The results of the 2012-13 audit of

fractured neck of femur treatment showed improvements since it was last audited in 2004, but also highlighted several areas where performance could be improved.

Competent staff

- The trust was actively recruiting nursing staff from overseas in order to fill vacancies. Once recruited, they were given more time than UK applicants to adjust to the NHS, and there was a specific induction course for them to complete.
- Nursing staff had access to mentorship programmes. They had annual appraisals with six monthly reviews. They had supervision, where senior staff assessed their clinical work and provided feedback to them.
- Staff reported that the use of medical locums at the weekend could be problematic, as not all of them had access to the computer system, and therefore needed another doctor to be present when they used it.
- There were concerns that the volume of work for specialist registrars would hamper their ability to deliver training to more junior doctors.

Facilities

- It was noted that whilst there were nine theatres that were operational, there were four others that were not in use. Staff held mixed views on what further resources would be needed to make these operational and financially viable, though it was noted that staffing, costs and a possible upgrading of the facilities were all factors.
- It was also noted that there was limited space within the theatre recovery area. Staff reported that some procedures had to be put 'on hold' until a space was likely to become available in recovery.

Multidisciplinary working

- Nursing staff said that when they requested it, surgical staff attended promptly.
- Other healthcare professionals, such as physiotherapists (PHYs) and radiological staff, were available on request. However, some staff (across the department) did report delays in getting radiological assistance in some cases (such as with ultrasounds).
- Staff spoke positively of the access to, and support provided by, the Macmillan nurses on site. They also spoke positively of the discharge teams, and the attendance of the therapy teams at discharge planning meetings.

Are surgery services caring?

Good

People that we spoke with praised the quality of nursing staff. Patients said that they were well looked after and supported, and we observed this taking place. However, some patients told us that the medical staff were rushed, and sometimes they did not feel that their care or treatment had been fully explained to them so that they could understand it.

Compassionate care

- The majority of patients were observed to have a named nurse and consultant listed on a poster above their bed whilst on the wards. All nursing staff that we observed wore name badges.
- We spoke to ten people using the service. They told us that they were happy with their treatment and the way that they had been looked after and supported by staff. We observed this taking place.
- We observed numerous examples of patients being treated with care and consideration. Their privacy and dignity were respected, with curtains being used round their beds when personal care was being delivered.
- Friends and Family Test results show that slightly worse than the national average.

Patient understanding and involvement

- One patient told us that they had been provided with an explanation of their condition by staff.
- Some patients said that their time with medical staff had been brief, and they did not feel that they had received full explanations of their condition/treatment. In addition, staff noted that the main issue raised in complaints was usually a lack of, or poor, communication with patients. However, some staff reported that junior doctors did sometimes return after ward rounds to further explain matters to patients.

Emotional support

- Staff had access to the bereavement services within the trust, as well as to different religious persons, should patients, relatives or carers require such support.

Are surgery services responsive?

Surgery

Requires improvement

Surgery services are not responsive to the needs of individual patients as the trust is not meeting the referral to treatment times and there are delays in discharging patients. Whilst the surgical services had plans in place to deal with increases in demand for the service during the winter months we found that patients were being kept in recovery overnight as there were no beds available on the wards. This is not responsive to their needs. Despite nursing staff planning for discharge on admission there was a delay in medical staff prescribing take home medication which led to a delay in discharges.

Staff were aware of complaints and the learning from these. A range of food was available as were translation facilities for those who required these services.

Service planning and delivery to meet the needs of local people

- The department operated a winter plan, to increase their resources across the winter months, to account for the greater volume of patients.
- The department had also put in place plans for previous major events in the local area, to be able to handle possible increases in the number of patients attending for surgery.
- The trust had failed to meet its targets to treat patients within 18 weeks of referral. Currently there were between 800 and 1,000 patients awaiting treatment over 18 weeks. The trust had written to patients to apologise for the delays in treatment.

Access and flow

- Staff reported that the introduction of the Surgical Assessment Unit (Fletcher Ward) had made a positive difference to waiting times and to patient flow through the hospital.
- On some occasions, a lack of beds available on wards meant that patients spent the night in the recovery room, which delayed the morning surgical lists.
- Discharge planning started pre-admission, or on admission, and would involve numerous professionals, including occupational therapists and social services where appropriate. Discharge plans were monitored as part of the daily handover.
- There was a specific risk assessment to be completed before patients were discharged. This looked at what the needs of the patient were, the plans needed to be made, and the resources to be put in place before they were discharged.
- Staff reported that due to the low numbers of medical staff, patient discharge could be delayed as they waited for a doctor to sign for the medicines that they were to take home with them.
- Staff spoke positively of the discharge planners and how they supported patient arrangements to go home.

Meeting people's individual needs

- There were a range of food options to meet people's cultural or religious needs.
- Translation services were available if people needed them, but staff would also utilise their colleagues who could speak different languages.
- The department had a dedicated learning disabilities nurse.
- Staff received training in caring for a person with dementia.

Learning from complaints and concerns

- There was a process in place for the receipt, investigation of, and feedback on, complaints.
- Staff reported that they received complaints as well as positive patient feedback. We spoke with staff about recent complaints, and they were able to describe the actions they had taken to address patients' concerns.

Are surgery services well-led?

Requires improvement

There were suitable measures in place for staff to be able to monitor the safety and quality of the service they were providing. However, whilst it was noted that areas for development and improvement had been highlighted, as had possible solutions, the implementation of these changes did not appear to be happening in a timely fashion, putting patients at continued risk. Staff praised their team environment, and were positive about the senior staff at the trust.

Surgery

Vision and strategy for this service

- Whilst staff had an idea of the performance of the department, where improvements were needed, and the general plans for making them, staff were not clear on how or when these improvements would be made.

Governance, risk management and quality measurement

- The department collected suitable information on both the safety of the service and the quality of outcomes of treatment.
- There were regular meetings of senior staff, both nursing and medical, where performance was discussed and plans were made to address any issues.

Leadership of service

- Staff spoke positively about the current senior management within the trust, and said that they retained the confidence of senior medical staff.
- A number of staff said that senior trust figures had visited their wards. Nursing staff stated that the assistant directors of nursing were visible on the wards and described them as “effective”.

Culture within the service

- Staff that we spoke with, at all levels, described friendly and supportive relationships within the surgical services team. However, numerous staff remarked about the pressure they and their colleagues were under.

Public and staff engagement

- The department obtained feedback from patients and relatives via the Friends and Family Test (FFT). However, aside from this, and the spontaneous feedback provided by patients and their families, the department did not employ a method to obtain systematic in-depth feedback on the quality of the service they were providing. Senior staff reported that they had plans to introduce a more in-depth patient questionnaire in the near future.

Innovation, improvement and sustainability

- Senior staff reported that they had raised numerous concerns about the risks they saw throughout the department relating to capacity, resources and the pressures currently being experienced. They said that these concerns were often noted and plans were developed to mitigate them, but despite this, little had improved within the department.

Critical care

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

Information about the service

Critical care at Northwick Park Hospital was based across three different wards, two high dependency units and an intensive treatment unit, with a total of 19 beds. They also had dedicated beds on the recovery suite.

Summary of findings

Critical care at Northwick Park Hospital was based across three different wards, two high dependency units and an intensive treatment unit, with a total of 19 beds. They also had dedicated beds on the recovery suite.

Critical care

Are critical care services safe?

Requires improvement

Critical care services require improvement to ensure that services are safe. We saw that staff used hand washing gels and adhered to infection control procedures but audits showed that in only 69% of opportunities staff undertook this basic hygiene step. Medical staff were functioning at a level below their grade which meant that experienced staff were doing more menial tasks.

Very little data was collected on the overall performance and safety of the department, and medical staffing numbers were low. Nursing staff undertook appropriate assessments and audits to ensure that patients were safe on a daily basis. The general environment of the department was appropriate. However, very little data was collected on the overall performance and safety of the department, and medical staffing numbers were low.

Incidents

- Between December 2012 and January 2014 five serious incidents took place in intensive care / high dependency units within the trust as a whole, and these were reported to the Strategic Executive Information System (STEIS). Between February 2013 and March 2014 four incidents were reported to the National Reporting and Learning System (NRLS), all of which were given a rating of 'moderate' severity.
- There was a procedure in place for incidents to be reviewed and learning taken from them. Appropriate staff were kept up to date with the outcomes and any relevant changes to practices or procedures.
- Staff reported that mortality and morbidity meetings did not take place on a regular basis. We were told that deaths were discussed at weekly multidisciplinary meetings. However, these did not constitute an in-depth review of the circumstances of the death and if any learning could be taken from them.

Safety thermometer

- Staff monitored the safety of the department using a 'safety thermometer', whereby the number of patient falls and pressure ulcers (amongst other indicators) where monitored. At the time of the inspection no significant safety issues were highlighted by this tool. The results were displayed on the units.
- However, the quality assurance and clinical governance within the department was poor. As such, little other information was systematically collected about the performance of the department to ensure that it was safe. This included data about unplanned extubations, readmissions and mortality.

Cleanliness, infection control and hygiene

- Staff reported that infection control audits took place on a regular basis, and we saw evidence of this. This included monitoring the number of healthcare-associated infections of patients, as well as compliance with hand washing protocols and the general cleanliness of the department's environment. We reviewed this data and noted that the number of infections was low.
- During the inspection, the clinical areas we visited were clean and tidy. We observed staff adhering to infection control policies and procedures, such as the use of personal and protective equipment (gloves, aprons, etc.) and hand washing. However, it was noted that in a recent audit compliance with hand washing protocols was low (69% of opportunities taken to wash the hands of staff).
- The infection control policy was not readily accessible to all staff.

Environment and equipment

- Emergency equipment and drugs for resuscitation were available throughout the department, and there were checks on these to ensure that they were in good working order and in date.

Medicines

- Medicines were securely stored and were accessible only to authorised staff.

Records

- We reviewed a selection of patient records. All had appropriate risk assessments completed, such as nutritional and pressure ulcer risk assessments.
- Clinical observations and medication administration records were complete and up to date.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff undertook mandatory training in consent, the Mental Capacity Act and Deprivation of Liberty Safeguards.

Critical care

Safeguarding
- Staff undertook mandatory training in safeguarding vulnerable adults. There were guidelines and protocols about how staff should act on any concerns identified on the units.

Mandatory training
- Staff undertook mandatory and refresher training on a regular basis in appropriate topics, including basic life support and infection control.

Management of deteriorating patients
- The department used the national early warning scores (NEWS) system to alert them to when a patient's condition may be deteriorating.
- There was a specific policy in place covering the management of deteriorating patients, which included details around observation and monitoring of patients, as well as the clinical responses. This was written in March 2013 and had been scheduled for review in March 2014.

Nursing staffing
- Nursing levels were based upon Royal College of Nursing and the British Association of Critical Care Nurses guidelines.
- There was a high proportion of senior grade nurses (65% at band six or seven), with 35% at band five.
- New nursing staff would be supernumerary for their first month so that they could learn about the service.
- We looked at previous rotas, which confirmed that the planned nursing staff levels were maintained over time. However, it was considered that the number of support staff, such as housekeepers or healthcare assistants, was lower than expected for the number of beds in the department.
- We observed a staff handover where an electronic handover tool was used to good effect.
- At the time of the inspection there had been a 22% uplift in the staffing budget to cover for staff on maternity leave in the department.

Medical staffing
- Nursing staff we spoke with were positive about medical staff attending when they were needed.
- An outreach team operated throughout the hospital 24 hours a day five days a week, and 12 hours a day at weekends.
- However, in general, medical staffing levels were very low. A large number of positions were filled by locums and clinical fellows. The trainees in the department were very junior and unable to take on many tasks independently. Whilst the number of consultants on the wards was appropriate to the number of beds and acuity of patients, because of the lack of junior grades they undertook tasks more suited to senior registrars. There had been no clinical lead in the department for the previous 12 months, although it was noted that a clinical lead had been appointed the week prior to the inspection. As a result of these low medical staffing numbers, the workload for consultants was considered to be excessive.

Major incident awareness and training
- There was a process in place for managing an increase in the number of patients and how this was to be escalated, which was utilised by staff on a regular basis.

Are critical care services effective?

Inadequate

Whilst nursing staff received the supervision and support whilst new on the unit the medical staff did not. A large number of locums were used to ensure adequate medical staff were available however there were no medical policies or procedures for staff to follow. This meant that patients could be getting significantly different levels of care from the doctors who treat them as there is no guidance to follow. The trust did not, during the time of the inspection, subscribe to a national audit of the intensive care services. While this is not a requirement, the trust should have a process in place to assess and monitor the quality of the service it delivers. However, only very limited information was collected on patient outcomes on the units under the NW London audit programme. On some occasions, patients were discharged before they were well enough and therefore had to be readmitted. This was particularly evident for patients admitted to the St Mark's Hospital.

Evidence-based care and treatment
- Staff used the national early warning scores system to monitor the condition of patients. They used industry standard risk assessments, such as the Waterlow pressure ulcer tool and the MUST (Malnutrition Universal Screening Tool) system.
- There were trust-wide policies available on the intranet, which provided general guidelines on providing nursing

care, and these were mainly up to date. However, there were very few protocols for medical staff. For instance, there were no protocols on important aspects of critical care such as sedation, management of septic patients or renal replacement therapy. This posed a risk of inconsistent or inappropriate care and treatment of patients. In addition, because these protocols were not in place, senior staff were very limited in what treatment they could delegate to junior medical staff to carry out, and had to treat patients themselves.

- Nursing staff undertook some audits such as the NW London audit, which included the activity of the outreach team and on late discharges, but the outcomes of these were not available at the time of the inspection. They also told us that they collected the Critical Care Minimal Data Set, but evidence of this was not available either.
- Very little reliable information was collected on the activities and treatment outcomes for medical staff. The trust was not a member of the Intensive Care National Audit and Research Centre (ICNARC) and did not participate in their audits. As such, their performance was not nationally benchmarked. The trust was however, a member of the North West London Critical Care Network, which was a group of local hospitals who audited their own work according to their own criteria, and then benchmarked this against each other. This did include some of the data that would be collected by ICNARC. In addition, for at least the year prior to the inspection, this data had not been systematically collected by the trust. As such, staff were unable to tell us key information about their performance and the outcomes of their treatment. They were unable to measure their performance against local or national standards.

Pain relief

- There were written protocols for nursing staff on the provision of analgesia for the alleviation of patients' pain.

Nutrition and hydration

- We reviewed the records of six patients across the trust. Nutrition and hydration risk assessments had been completed where appropriate. Fluid balances were recorded on a daily basis, and there were daily nursing evaluations of nutrition and hydration. There were records of the involvement of a dietician where appropriate.

Patient outcomes

- Due to the lack of reliable information collected on a consistent basis, it was unclear what the outcomes of treatment for patients were.

Competent staff

- Nursing staff begin working in the department as supernumerary for the first month, so that they can learn about the department. Staff were supervised on a regular basis.
- The nursing staff members that we spoke with said that they felt well supported. They said that they had time to attend their mandatory training and that they had annual appraisals on their performance.
- However, medical staff's development was not similarly supported. Due to the lack of middle grade doctors and the junior nature of the trainees, workloads were very high, particularly for consultants. Some staff did note that this meant they had extensive and varied caseloads. However, due to the staff shortages, consultants reported that they were working as senior registrars and had very little time for teaching or training. This was compounded by the lack of protocols and procedures, which meant they were unable to free some of their time through delegation.
- Trainees reported that they were given time off to attend courses.
- Medical locums were used extensively throughout the department. The quality of the locums was described by staff as variable. In addition, not all locums had access to the computer system, so they were reliant on other medical staff being present for some of their duties.

Facilities

- The pressure on the CCU department was noted throughout the inspection, in particular the pressure on the number of beds. Staff reported that due to this pressure, some patients were discharged too soon and later had to be readmitted to the CCUs.

Multidisciplinary working

- Multidisciplinary team meetings took place on a weekly basis. This would include consultants, ITU trainees, the microbiologist, nursing staff, as well as other relevant healthcare professionals. We observed one of these meetings taking place. Staff discussed each patient's case, and the monitoring and investigations that were needed, and care plans were drawn up.

Critical care

Are critical care services caring?

Good

Staff on the CCUs were caring. We observed positive interactions between staff, patients and their families. People were kept informed about their care and treatment, and were involved in making decisions when possible.

Compassionate care

- Throughout the inspection we saw patients and their families being treated in a kind and considerate manner by staff members.
- Patient's dignity and privacy was respected throughout, with curtains being drawn around cubicles when care and treatment was being provided. We observed active use of 'do not disturb' notices being utilised by staff appropriately when delivering care to patients.

Patient understanding and involvement

- There were written records of family members being involved in the planning of and decisions about patients' care and treatment.
- In one record we reviewed, staff had documented the discussion they had had with a patient's family about resuscitation.
- Staff described the visiting hours of the department as "open door" and said they were flexible about when people could visit their relatives.

Emotional support

- Staff had access to the trust's bereavement services, as well as a range of religious persons who provided emotional support to families/carers as required.

Are critical care services responsive?

Requires improvement

There was a policy and procedure in place that informed staff how to handle complaints and concerns from people. Translation services were available to assist people who spoke limited or no English. However, the department was under considerable pressure and at times discharged patients before they were well enough, which often resulted in them being readmitted. This led to additional pressure on the whole system at the hospital and the nursing and medical staff. This was not responsive to patient's needs. .

Service planning and delivery to meet the needs of local people

- There was a procedure in place to deal with a temporary increase in the volume of patients to be treated. Patients could be moved between the different types of units within the department according to their needs, and there was a dedicated member of the anaesthetic team who made these decisions.

Access and flow

- During our inspection we noted that the service was experiencing very high levels of patient demand in relation to the numbers of available beds. Low staffing numbers exacerbated this problem, which had existed throughout the past year. Whilst interim measures had been taken to addresses this problem, there appeared to be limited plans to tackle the lack of capacity issue overall. Staff reported this as a major concern of theirs. They noted that this had resulted in patients been discharged at night and also being discharged before it was medically safe to do so, resulting in the patients being readmitted within 24 hours.
- **The lack of reliable data collected by the service meant that it was not possible to judge the scale of the problem, but staff described it as being "very serious".**

Meeting people's individual needs

- The service had access to translators if needed, and these were well advertised on the wards. However, it was noted that on the intensive treatment unit the dual phones could not be brought to patients' bedsides.
- Following their discharge, all patients who had stayed in the CCUs for three days or more were invited to attend up to three follow-up outpatient appointments, in order to check on their progress.

Learning from complaints and concerns

- When complaints were received, they were logged on to a specific computer system by administration staff, who also recorded any actions taken and escalated the issues if necessary. However, it was noted that no other staff members other than the administration staff had access to the database.

Critical care

Are critical care services well-led?

Inadequate

Critical care services were not well-led. There had been no clinical lead for the preceding year. Whilst concerns about the department's performance and safety were widely acknowledged within the staff base, but there had been no significant action taken to address the concerns. Staff were over-worked and under-resourced to be able to make any changes. It was not considered that the service would be able to develop into a service that provided safe, high quality care without a significant investment from dedicated leadership. Until this occurred, patients would continue to be placed at an unreasonable level of risk of harm.

Vision and strategy for this service

- There was no overall strategy or vision in place for critical care services. It was noted that there had been no clinical lead for the past year, but staff reported that one had been appointed in the week prior to this inspection.

Governance, risk management and quality measurement

- There were systems in place for governance, risk management and quality measurement within the department. There were specific data items that needed to be collected by staff relating to nursing and medical care, as well as other measurements, which had direct relation to the quality and safety of the care and treatment being provided. However, large amounts of this data were not collected or reviewed on a systematic basis. No systematic feedback was provided to staff. There was no facility for this information to be benchmarked on a national basis. In addition, due to the sporadic collection rates, it could not be benchmarked against the local hospitals who used the same system as the trust. This posed very significant risks that poor care, trends of worsening care and risks to the patient safety could be missed and not acted upon.

Leadership of service

- Nursing staff within the critical care services described a positive environment to work in (though a very pressurised one) and said that they felt well supported.
- Medical staff described working in a leadership vacuum, and said that they had serious concerns about the on-going safety of the department. The lack of vision, strategy and governance within the department were indicative of this.

Culture within the service

- The main feedback from staff was that there was no leadership. Staff were under immense pressure (in particular medical staff) and stated that they were 'fire-fighting' with no capacity to improve.

Public and staff engagement

- Whilst the trust received the results of their 'Friends and Family Test', and people could make complaints or comments, no further efforts were made to engage with members of the public.
- Staff had raised their concerns with senior directors, but it was noted that the lack of a clinical lead could be contributing to the delays in changes taking place.

Innovation, improvement and sustainability

- Staff reported that due to the pressure that the department was under, there was very little time for them to reflect on practice, and there was no opportunity to undertake research.

Maternity and family planning

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

Information about the service

North West London Hospitals NHS Trust offers the full range of maternity and family planning services. In 2013/14 the trust delivered 4,900 babies. Almost all deliveries within the trust take place at Northwick Park Hospital. Antenatal clinics are held at Northwick Park Hospital, Central Middlesex Hospital and local children's centres. There are a number of dedicated hospital clinics for women with diabetes, blood disorders, HIV, teenagers and women with multiple pregnancies. There is an African well-woman clinic one day a week, and also clinics for people with mental health needs.

Northwick Park Hospital has a midwife-led birthing unit, which is designed for women assessed as having a 'low risk' pregnancy. It has six birthing rooms, two of which are fitted with birthing pools. The main delivery suite has 11 delivery rooms, four high dependency beds, four recovery beds, one triage assessment room, four observation trolleys and two dedicated obstetric operating theatres. There is a community midwifery service and a home birth service. Only 0.2% of births are home births.

We spoke with nine women and their partners, and 40 staff members including domestic staff, care assistants, midwives, nurses, doctors, consultants and senior managers. We observed care and treatment, and looked at eight care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

The maternity service has improved standards over the past 10 years but still has some improvements required. The unit was not meeting some of its performance targets. Although risks to the service had been identified and were being monitored, there was a lack of pace and joined up action between obstetricians and midwives that that would result in minimising risks to women using the service.

We saw that laudable attempts were being made to introduce changes that would deploy the midwife workforce more flexibly, but further effort was needed to win staff support and embed these changes for the benefit of women and their babies. The maternity service did not respond to complaints in a timely manner, nor did it actively seek women's feedback on the maternity pathway. We found evidence and women corroborated that the service they received in the unit in the most part fell below their expectations. Significant engagement with women and their families is required to ensure that the caring element of this service improves.

Maternity and family planning

Are maternity and family planning services safe?

Requires improvement

Historically, there had been safety issues in maternity services at Northwick Park Hospital. However, the maternity service now had a better track record on safety, based on the data on the maternity dashboard and the intelligent monitoring report carried out before our inspection. Midwives considered the service to be safe.

A number of incidents had occurred. Although systems were in place for reporting and reviewing these, the process was too slow to make a strong impact and needed to change. Medical staffing levels were sufficient. There were also sufficient midwifes, but they were not deployed to best effect at all times. For example, the number of women with one-to-one support in labour was lower than would be expected given the number of midwives employed (on average only 92% of women had one-to-one support in the previous year).

Incidents

- There had been four maternal deaths in the last two years, and four infants died unexpectedly during 2014. One mother died after her discharge.
- There was one 'never event' in 2013/14; a retained swab in a patient. ('Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.)
- In 2013 there were six admissions to intensive care at Northwick Park Hospital and a seventh patient was transferred to intensive care at a tertiary centre.
- The unit closed four times in 2013/14, once because of smoke in the unit and at other times because of capacity issues.
- The labour ward and deliveries accounted for 26.2% of serious incidents in the trust.

Safety thermometer

- There was no specific safety thermometer for maternity services.
- There was a maternity dashboard in place which highlighted performance against safety-related targets on a monthly basis. This included indicators such as staffing levels, admissions to the neonatal unit, still births and admissions of mothers to intensive care. The dashboard was discussed at monthly divisional risk meetings, and performance concerns were investigated. However, many areas remained 'red–rated', the highest level of concern, month on month.
- The previous month's delivery statistics were widely displayed in clinics. For April 2014, 96.67% of women had one-to-one attendance from a midwife, 58.7% of deliveries were normal births, 25% of women had caesarean sections and 16% had other interventions during delivery.
- The trust had achieved the clinical negligence scheme for trusts (CNST) risk assessment as level 1 in November 2012. (This is the level achieved by most trusts.)
- The trust appeared to assess the risk of mothers through using the Birthrate Plus workforce planning tool. However this tool looks at dependency rather than risk. True risk should be assessed from mother's risk factors at booking.

Cleanliness, infection control and hygiene

- We observed the clinical environments of the antenatal and postnatal wards, and of the birthing unit, to be clean and tidy. Hand washing facilities, alcohol gel and personal protective equipment were available and used by staff.
- We noted that cleaning schedules were not displayed, and domestic staff did not carry checklists of the cleaning to be done that day or week.
- In some clinics, notably the sexual health clinic and the antenatal clinic, the accommodation was 'shabby' and there was insufficient seating. A domestic assistant also mentioned the desirability for more regular deep cleaning to the clinical areas.
- Between January 2013 and March 2013, more incidents of puerperal sepsis had been reported than were expected. The trust was asked by the CQC to investigate and it was found that some patient notes had been incorrectly coded, which had led to misreporting. Wound infection rates had reduced, but remained slightly above the national average.
- The service had twice the national rate of early onset Group B streptococcal septicaemia of new-borns, an infection that makes babies very sick. There had been 17 instances of this infection in the six months ending March 2014. The hospital had noted that there was a

high incidence of the bacterium in the local population, although it did not usually cause infection in older people. Appropriate women were now being screened for this infection.
- There had been no MRSA or C. difficile infections in the maternity services.

Environment and equipment
- Used needles and other sharp items were left on the lid of the sharps bin in the operating theatre. This presented a potential infection risk to staff.
- There was no maintenance log for the gas analysers, which was a potential risk to patient safety.
- Staff were not all 'bare below the elbows' for the theatre briefing, in contravention of the trust's policy. This posed an infection risk to staff and patients.
- There was sufficient equipment in each area visited to ensure that patient safety was maintained. For example, there was a resuscitaire in each of the seven delivery rooms on the delivery suite, as well as two in the obstetric theatres, plus a spare.
- Staff told us that they had a sufficient number of CTG (cardiotocography) monitors, which are used to monitor the foetal heartbeat during labour.
- Resuscitation trolleys were checked daily and weekly by appropriate staff. Equipment and drugs were reordered as necessary.
- Staff told us that there were not enough computers, which limited staff productivity. They said that they had been told that this was being addressed.
- Entry into the maternity service was not secure at night. Several staff members mentioned that a homeless person sometimes came and slept in the waiting area of the antenatal clinic. However ward areas were accessed by entry phone and/or swipe cards. This was secure. Babies were tagged appropriately.
- Staff were aware of emergency procedures, and practice drills were undertaken to test staff reactions. The most recent scenario was the practice drill of the abduction of a new born baby.

Medicines
- There were appropriate arrangements in place for the safe storage of medications in clinical areas.
- Drug fridge temperatures were checked daily and recorded. Controlled drug checks were completed appropriately.

Records
- Comprehensive antenatal assessments were carried out when mothers registered with the hospital. Records incorporated any health or social risks to the mother or unborn child, on which the plan of care was based. Where appropriate, the booking assessment triggered a referral to a relevant service. For example, if a woman had a cardiac condition they may be referred to a consultant anaesthetist to determine what pain relief could be provided during labour.
- All women were given a 'red book', also known as the Child Health Record, which provided information on the health of their baby and the immunisations they would be expected to have.
- The hospital was part of the programme to give all babies an NHS number as part of the statutory birth notification process. However, this was not 'owned' by the consultant body, which was a barrier to full implementation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
- Expectant mothers gave their consent for surgery and for instrumental procedures to be carried out. However, an audit in 2013 noted that consent for instrumental intervention was poorly documented. We did not see a recent audit.

Safeguarding
- There were systems in place to identify and protect vulnerable people from abuse. Staff received safeguarding training in line with the trust's mandatory training.
- The trust policy was that all doctors, midwives and healthcare assistants working in the maternity department received level 3 child protection training. Student midwives attendance of training in safeguarding was low; only 16% had attended level 2 or 3 child protection training.
- Staff we spoke with were able to describe the process for reporting any concerns to social services and to identify the midwife team responsible for safeguarding.

Mandatory training
- On average, 58% of staff were up to date with mandatory training in the women's directorate. Staff in antenatal clinics and the gynaecology department had the lowest completion rate of mandatory training.

Maternity and family planning

Assessing and responding to patient risk

- MEOWS (Modified Early Obstetric Warning Score) charts were used to record physiological observations in pregnancy, and to spot women whose condition may be deteriorating.
- The SBAR mechanism (Situation, Background, Assessment, Recommendation) was used by staff to communicate critical information in emergencies.
- Handovers between midwives and obstetricians took place at different times. Anaesthetists often missed part of the doctors' handover because they were busy clinically, but we saw effective exchange of ideas between anaesthetists and obstetricians. The absence of midwives from the doctors' handover meant that midwives were excluded from doctors' discussions of management plans for difficult cases.
- Consultant to consultant handover on labour ward took place when there had been a consultant resident overnight (4 out of 7 nights).
- Consultant ward rounds took place daily.
- In the operating theatre, the team briefing we observed was ineffective, because the theatre list was not available to all staff. Were told that the list order often changed at the last minute. The anaesthetist was not present for the briefing. During 'time out', the names of staff were not written on the board, and we noted that the information was spoken inaudibly. The senior house officer for obstetrics was not present and there was little focus on safety in the briefing; for example, on antibiotics or allergies.

Midwifery staffing

- The midwifery establishment was 192 WTE, which gave a theoretical birth to midwife ratio of 1:24 compared to a national recommendation of 1:28. The recommended birth rate plus ratio was 1:25. (Birth-rate plus enables trusts to calculate staffing based on their specific activity, case mix, demographics and skill mix.)
- Levels of sickness absence among the midwifery team were high, at 5.7%. There were plans to manage sickness absence more tightly, with stricter return to work interviews. The service was also trying to tighten annual leave policy to enable better planning, but these measures were not yet in place.
- The only vacancy within the new midwifery structure was for the consultant midwife for normality.
- The maternity department used both bank and agency staff, especially at weekends. They aimed to reduce this, to 20 WTE a month from bank, and 5 WTE from the agency.
- Antenatal clinics displayed the expected and actual numbers of staff on duty.

Medical staffing

- There was 108 hours consultant presence in place, which met the standard set by the Royal College of Obstetricians and Gynaecologists (RCOG), although this level was not compliant with the Department of Health recommendations, "Towards Safer Childbirth". This was on the maternity risk register.
- There was appropriate cover from junior and middle grade doctors during the day. There was a resident on-call consultant obstetrician for four nights a week; the other three nights were covered by off-site consultant obstetricians.
- There was concern that following a critical General Medical Council report, the number of trainee doctors would be reduced. This would have a negative effect on medical cover in future.

Major incident awareness and training

- Midwives and healthcare assistants did regular obstetric skills and drills, but not all midwives were believed to be equally competent in all areas. There were plans to rotate midwives through different posts in order to up-skill the workforce.
- There were major incident plans in place, and simulations were run periodically.

Are maternity and family planning services effective?

Requires improvement

Care was based on nationally-recommended guidelines and standards. Patient outcomes had improved in some areas over time, but there was little change in other areas. The proportion of 'normal' births remained lower than the national average. Actions had been planned to reduce the number of caesarean sections and other birth interventions, but there was, so far, little evidence of impact.

Maternity and family planning

Maternity care involved multidisciplinary, community and other teams within the trust, as well as external organisations, such as GPs and social services. There was sufficient equipment to provide effective care, and staff were trained on how to use them. Mandatory training completion rates and staff appraisal rates were lower than in other trusts, and not all midwives were keeping their clinical skills and knowledge up to date.

Evidence-based care and treatment

- Patient's needs were assessed, and care was generally delivered in line with best practice clinical guidelines, including those produced by NICE and the RCOG. These were applied to patients based on their clinical need, to ensure safe and effective care.
- The trust had a guidelines group that reviewed guidelines. However, not all guidelines were up to date. For example, the AIDS protocol, (in the sexual health clinic), was out of date and should have been reviewed in 2011.
- All clinical guidelines and protocols were available to staff through the trust's intranet.
- Although the trust had achieved a successful audit from the London Quality Assurance Reference Centre for cervical cancer, we noted that the evidence-based guidance on 'see and treat', the precursors of cervical cancer screening, had not been adopted as standard.
- Audit practice was variable. Of the audits logged on the trust database in the previous year by the directorate, only 30% had been completed, which meant that opportunities were being lost to monitor practice against national and local standards.

Pain relief

- Pain relief was available, and most women we spoke with reported that pain control was not a problem.

Nutrition and hydration

- Some mothers on the postnatal ward reported that the light lunchtime menu was inadequate for breastfeeding mothers.
- Staff supported new mothers with breastfeeding.

Patient outcomes

- 73.3% of women booked with the hospital before their 12th week of pregnancy, compared to a national target of 90%.
- The hospital had been an outlier for puerperal sepsis (May 2013) and for emergency caesarean section (July 2012). Puerperal infections were above the national average, however an audit had identified that some of this was due to miscoding and a repeat audit had shown that it was no longer an outlier.
- There had been 43 in-transit births and six unplanned home births, in the last 10 months to February 2014.
- The median length of stay in the hospital was two days.
- 87.5% of women were breastfeeding when they left hospital.
- Perinatal mortality was higher than the England average.
- The trust had higher emergency caesarean section, and lower forceps cephalic delivery and ventouse delivery rates compared with nationally. The trust's normal delivery rate, 56.8%, was lower than the national rate. Elective caesareans were at a similar level to the national level.
- Unexpected admission to NICU (neonatal intensive care unit) was the second highest origin of incidents, with 15.9%.
- There had been seven maternal unplanned admissions to ITU in the 10 months to February 2014.
- Maternal readmission rates were 2.48%. This was higher than the England average.

Competent staff

- The appraisal rates for staff in maternity and gynaecology were low; around 30%. The highest rates were for specialist midwives at 57.9%.
- All midwives had a named supervisor. The supervisor of midwives ratio was 1:13, which was generous. The norm was 1:15.

Multidisciplinary working

- Care and treatment was delivered by multidisciplinary teams, ensuring that people were cared for by the most appropriate person at the right time. There were specialist midwife roles for bereavement, breastfeeding and safeguarding, who acted as a source of support for staff and women.
- Staff shared information with the trust's integrated community services. Referrals were made to social services, health visitors or specialist hospitals, where there were concerns about an individual woman.
- The maternity services liaison committee (MSLC) had a Facebook page and advertised regular maternity debrief

sessions, facilitated by a supervisor of midwives. It was reported that this had led to a 40% reduction in complaints against the service, although we did not see evidence of this.
- A senior member of staff mentioned that the Brent and Harrow Clinical Commissioning Groups were not engaged with maternity services, despite commissioning for them.
- We saw evidence of good teamwork amongst staff on the wards.
- Where women's care was shared between the trust and GPs, all test results were sent to the women via the GP.
- There was transitional care of babies from the special care baby unit in the postnatal unit. Of note was the opportunity for terminally ill mothers to remain with their babies.
- There was access to specialist medical support at tertiary centres, such as Queen Charlotte's Hospital in Hammersmith.

Seven-day services

- Clinics were provided Monday to Friday, although gynaecological scans were offered on Saturdays and evenings.
- Some consultants worked one weekend in four whilst some consultants did not participate in the on call rota.

Are maternity and family planning services caring?

Inadequate

Based on what other women told us, observations during our visit, and the results from surveys, it was clear that the standard of care was inadequate in a large number of cases. Whilst we did see and hear about good care evidence provided and women spoken to did not receive good care. Of three women we spoke with on the postnatal ward, only one woman's experience met best practice standards. We also received some negative feedback about the attitudes of some staff who had not spoken to colleagues in a professional way.

In the crowded antenatal clinics, we observed that not all discussions between women and clinical staff were private. Elsewhere in the maternity service, we saw records containing personal information left where others could see them.

Sensitive emotional support was offered to women who had abnormal scans or had been bereaved. There was a specialist bereavement midwife.

Compassionate care

- Staff appeared to be unaware of the potential value of patient input into service improvement.
- According to the 2013 CQC Survey of Women's Experiences of Maternity Services, women's experiences of labour and of the attitudes of staff were worse than in other trusts.
- We were told that the behaviour and attitudes of some midwives (perhaps 10%) towards women fell below expectations. One midwife told us that new staff just got used to some behaviours and attitudes, and would not challenge them.
- Staff mainly treated patients with dignity and respect. We observed staff interacting with women in a kind manner. Staff knocked on doors or announced their presence before entering a curtained area. However, comfort checks on the postnatal ward were not regular, with the risk that some people were left without pain relief when it was needed.
- We found a handover sheet containing confidential personal information left out inappropriately. A midwife disposed of these correctly when we pointed it out and recorded our finding as an incident.
- The response rates to the Friends and Family Test were low. Community midwifery was rated higher than hospital experiences. A number of initiatives had been put in place to increase user satisfaction, including 'customer care' and 'compassion in practice'.
- The CQC survey 'women's experiences of childbirth 2013' showed the trust as performing worse in 50% of the responses, with no improvement since the 2010 survey. An action plan had been developed, but had not made an impact at the time of our inspection.

Patient understanding and involvement

- Women we spoke with were positive about the time and information they got from their community midwife.
- We saw from the notes of some women who did not speak English that family members had been used as interpreters, which was non-compliant with best practice recommendations set out in CMACE (Centre for Maternal and Child Enquiries) 2011.
- Women said that their conversations with clinical staff were not always private.

Maternity and family planning

- Most women did not have a named midwife. Several women we spoke with had not had an explanation of the antenatal care pathway and what to expect at each appointment, which contravened NICE guidelines.
- A woman referred for the antenatal mental health pathway at an earlier appointment had not been contacted about that referral, so had come to her next planned appointment at the regular clinic.
- Of three women we spoke to on the postnatal ward, the experience of only one met best practice standards, such that staff had introduced themselves, treated them well, stayed with them unless they wished to be alone, explained what was happening at each stage, and afterwards helped establish breastfeeding.
- A second woman, who had not had a named midwife, had three different midwives during established labour.
- A third woman in pain following a caesarean section was in a room with a bell that did not work. She had to telephone outside the hospital for help. This incident represented a system failure, a failure of care and a failure of escalation.

Emotional support

- There were systems in place to provide emotional and practical support for women and their partners. This included counselling and the opportunity to talk with a bereavement midwife. Memory boxes with footprints, locks of hair and baby photos were available if a bereaved parent wanted one. An appointment for psychotherapy was offered to bereaved parents if they wanted one.
- Women who had undergone a termination of pregnancy for medical reasons were also supported by the bereavement team. They could choose to be cared for on the delivery suite or the gynaecology ward.

Are maternity and family planning services responsive?

Requires improvement

There was a good flow through the service, and women did not have difficulty accessing the service when they needed to. Women were assessed to ensure that their needs were met. The maternity service was responsive to the diverse language needs of women who used the service, and interpreters were arranged where possible.

However, not all women had been given a clear explanation of what the service offered. Also, the majority of women did not receive continuity of care. Although we were told by many midwives that women were at the centre of care, people we spoke with, and survey responses showed, that this was not women's perception of the service.

There were specialist clinics to meet the different needs of women, including mental health, safeguarding, teenage pregnancy and diabetes.

Service planning and delivery to meet the needs of local people

- The trust worked with commissioners of services, local authorities, GPs, relevant groups and people who used the service, to understand and meet the needs of the local population.
- There was a monthly meeting with GPs about shared care. 25% of patients see GPs for appointments.
- Staff demonstrated an understanding of the demographic profile of women accessing the service. They were able to describe different vulnerable groups and how they planned services to meet their needs. An example of this was the way in which community midwives carried a portfolio of approximately 100 women and made 10 visits a day. Some midwives felt it was difficult to give sufficient support to women who did not speak English under the '10 visit rule'.
- Interpreters were arranged if required, when people booked appointments, but we observed family members undertaking this role.

Access and flow

- There was a good flow of women through the maternity pathway and we found no evidence of delayed discharges. However, there had been recent instances of too many women waiting to be triaged in the delivery suite and the service was addressing this.
- Bed occupancy of 68.7% was higher than the England average of 58.6%. Occupancy rates above 58.6% can start to affect the quality of care given to patients. This is relevant given the high rate of infection among mothers.
- Antenatal patients were referred to another provider if the there was a risk that the number of births would exceed agreed limits.

Maternity and family planning

- The gynaecology service had 20 breaches of the two week wait for cancer appointments, but on analysis this was mainly due to patients having other commitments, such as work or holidays.
- There was a home birth service available, which was provided by the community midwife team. Uptake of this service was low.
- Women attending the hospital did not have a named midwife, but were given a telephone number on which they could contact a midwife. This was unlikely to be a midwife they had met previously.

Meeting people's individual needs

- 90% of women using the service were from ethnic minority groups, and a high proportion were not fluent in English. Some written information was available in other languages. A contracted provider was used to provide translation services. Interpreters were arranged for women when they booked their appointment, but in practice this did not always happen.
- If the antenatal screening was abnormal, women were referred to the foetal medicine consultant and received written information on their options. Depending on the gestation period, a mother agreeing to a termination of pregnancy will have this carried out on either the gynaecology ward or the delivery suite. Late terminations after 21 weeks took place at a tertiary hospital. Women, who declined to have medical terminations, had a multidisciplinary care plan produced with appropriate specialists.
- Women and their babies were only discharged when they were well enough, and had the right support in place. Before women were discharged, staff checked that they knew when their community midwife would be visiting them. They were also given information on how to contact the service if they had any concerns.
- The waiting area in the antenatal clinic was cramped. Waiting times of an hour and a half were observed on our visit, and women told us that this was not unusual.

Learning from complaints and concerns

- There was little information in the antenatal clinic about how women and their partners could feedback on the service they had received, or how they could make a complaint.
- The number of complaints had reduced since 2012/13, but only 25% were responded to within the target time. Only 50% of those with an extended deadline for reply were dealt with in that time. We were told that there were delaying factors, included getting staff statements.
- The trust kept a database of complaints and gave feedback to staff. However, we had the impression that staff did not value the potential for learning that complaints could offer.
- The service actively engaged with women and encouraged them to share their experiences. Most women were offered a debrief session following their discharge, to discuss their birthing experience, to give them an opportunity to seek clarification, or to understand why certain things happened. This service was not just used by people who wished to make a complaint.

Are maternity and family planning services well-led?

Requires improvement

Clinical leadership in the department was poor. Obstetricians and midwives seemed to operate separately, without a shared vision on how best to provide high quality care to women. The maternity consultation paper, while grounded in best practice had been developed without involvement of obstetrician and midwifery staff.

New leadership in the midwifery service was proposing changes that would enable the services to have more consistent skills and greater flexibility to offer high quality woman-centred care. It was evident that building support for the changes would take time as new flexible working patterns and role changes were unpopular with some staff.

There was a clear governance structure for the service which ensured that risks were identified and performance was monitored and reported upwards to senior managers within the trust. However, the fact that many of the actions set out in plans were not sustained in practice was a concern.

Staff told us that the service did not have effective relationships with the external local Clinical Commissioning Groups.

Maternity and family planning

Vision and strategy for this service

- There was no shared vision for the maternity service.
- A 'maternity consultation paper' had been issued in January 2014, with proposals for improving the quality of care and the cost effectiveness of the service, through using midwives more flexibly. We were told some staff were resistant to the proposals to alter working patterns, and some senior midwives in particular, felt strongly that they should have been more involved in formulating the proposals.
- The consultation had ended in late February 2014, but staff had not had any further communication from management. Making a reality of the changes would need the support of trust managers and all maternity staff. The implementation date of the changes was originally 1 April 2014, but that timetable had already slipped.
- There was a strategy in place to encourage normal births, but midwives told us that "there was a long way to go" to achieve this.

Governance, risk management and quality measurement

- Maternity was part of women's services, which reported to the divisional general manager, who was also responsible for children's services. The governance structure ensured that there was reporting from the ward to board. Divisional governance was monitored by the trust's patient safety and quality committee.
- Quality and safety of care was managed using monthly performance dashboards.
- There was a maternity risk manager, whose role included following up incidents and monitoring any identified risks. There were 4,867 incidents open on the system, which was unacceptably high. A common issue running through incidents was communication. The introduction of the SBAR mechanism (Situation, Background, Assessment, Recommendation) was expected to show improvements over time.
- Senior obstetricians did not own take ownership of obstetric risks and there were evident tensions between midwives and obstetricians over risk management.
- A sample of incidents had been reviewed by an external person. Some incidents had shown good practice by staff, and where this happened, staff had been commended.
- There were systems in place to ensure that the trust met its legal requirements under the Abortion Act 1967. Abortions were only carried out for medical reasons, such as foetal abnormality, and had to be agreed to by two doctors.
- Senior staff were aware of the risks that may impact on the safety or effectiveness on the service, and these were logged on the trust's risk register and monitored at monthly risk meetings. Trends were also reviewed. However, risk information was not widely shared with relevant members of staff.

Leadership of service

- There appeared to be both poor working relationships between senior managers and poor working in multi-disciplinary teams.
- Staff told us that the hospital's senior management and board were not very visible. We were told that the number of senior staff in interim or acting posts created a sense of instability.
- Midwives reported that they were well supported by the supervisors of midwives, and all had an annual review. The supervisors also monitored their performance on an on-going basis, and midwives said all the supervisors of midwives were approachable. The trust had a supervisor to midwife ratio of 1:12, which was above the national standard.
- There was a lack of engagement from obstetricians in managing the service or driving change, such as to significantly reduce lower section caesarean section rates.

Culture within the service

- We did not detect a strong collective will for midwives and obstetricians to drive improvements.
- Midwives described the culture in the delivery suite as very dependent on the co-ordinator of the shift. There were different management styles, and some co-ordinators were perceived as less supportive than others. At weekends there were a lot of bank and agency staff, and teamwork was sometimes less effective as a result.
- Some staff mentioned tensions and differences of approach between some obstetricians and some midwives.
- Some midwives told us of their reluctance to speak out if they had a concern, and a fear of being 'judged'. However, other midwives sought out CQC inspectors to give their own positive views of the service.

- We were told that junior consultants were reluctant to challenge the clinical director.
- There was a high turnover of consultant staff within the department and we did not see evidence of exit interviews with these staff.

Public and staff engagement

- The chief executive kept staff informed of developments through the intranet, which staff said was helpful.
- The director of midwives held an open forum weekly between 8am and 10am in an effort to improve communication.
- The maternity services liaison committee (MSLC) had a Facebook page, and advertised regular maternity debrief sessions, facilitated by a supervisor of midwives. This had led to a 40% reduction in complaints from women.
- Senior staff mentioned that the Brent and Harrow Clinical Commissioning Groups were not engaged with the maternity services, despite commissioning them.

Innovation, improvement and sustainability

- The trust had produced an attractive credit card-sized prompt for staff about the strategy for compassion, quality and safety.
- The consultant to consultant handover on the labour ward was high quality.
- The feedback from junior doctors was that they received good supervision on the labour ward day and night.

Services for children and young people

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

Information about the service

Northwick Park Hospital has one 24 bedded children's ward with medical and surgical beds, known as Jack's Place. Up to three of these beds can accommodate high dependency patients. The local neonatal unit (previously known as Level 2) is based within the maternity block and has eight ITU/HDU cots and 20 special care baby unit cots. The unit cares for babies over 27 weeks gestation. The unit is part of the North West London Neonatal Network.

A paediatric day care unit (Chaucer) provides facilities for children requiring chemotherapy, diagnostic tests, consultations and follow-up appointments. The unit also provides day surgery. Northwick Park Hospital is a Paediatric Oncology Shared Care Unit (Level 1).

We spoke with five patients and three relatives, as well as 21 staff members including consultants, junior doctors, nurses, domestic and support staff. We observed care and looked at care records of six of post- operative or acute patients, and we reviewed other documentation, including performance information provided by the trust. We received comments from our listening event, and from people who contacted us to tell us about their experiences.

Summary of findings

Services for children and young people at Northwick Park Hospital require improvement. Children received effective care from staff trained to work with children. Staff engaged well with children of different ages. The facilities were generally good, particularly in the day care/children's outpatient area. Staffing and skill mix on the ward, the neonatal unit and the day care/outpatient service were sufficient.

However, there was insufficient space for storage of equipment on the children's ward, and some areas were cluttered.

Parents had confidence in the care that their children received, and spoke positively about staff's compassion and communication. We observed staff showing care and responsiveness to individual children. However, we found some areas where safety needed to be strengthened, such as ensuring that clinical equipment was not accessible to children on the inpatient ward, and that medical equipment was serviced annually.

There were arrangements to meet the diverse language needs of the population served by the hospital. However, there was a lack of joined-up working across the medical team, and between doctors and nurses. We also found that the service itself was distant from the trust board. There were no processes to obtain the views of the service from families and friends, although we were told that some ideas were being considered.

Services for children and young people

Are services for children and young people safe?

Requires improvement

Children services require improvement as there were a number of concerns about safe storage and maintenance of equipment. This related to medical equipment not being on the trusts asset register and potentially missing vital service dates. Wards were cluttered making it unsafe for patients, family as well as staff. We saw3 an example of this when a blood specimen was left on an open shelf where children could have reached it. There was evidence of safe care and readiness to learn from incidents, and to improve practice and procedures. Safeguarding practice was robust; however, many staff had not completed their mandatory training. Patient medical records were legible and up to date, including regular observations and risk assessments.

The service for children and young people had a low number of incidents and complaints, but when these occurred, they provided learning opportunities for staff. However numbers of people receiving mandatory training were poor and some staff did not have the appropriate level of safeguarding training.

Incidents

- The children's directorate had not reported any serious incidents or 'never events' in the last 12 months.
- Staff told us that incident reporting on the electronic system was improving, although there was a backlog of about 24 incidents for which, at the time of our visit, an investigation had not been started. Examples of incidents that had occurred included drug errors and the attempted abduction of a baby.
- There had been four unexpected neonatal deaths in the past year.

Cleanliness, infection control and hygiene

- Hand washing facilities were adequate, and hand gel and personal protective equipment (gloves, aprons, etc.) were available, and we saw them being used appropriately.
- There had been no cases of MRSA, C. difficile, or norovirus on the children's ward in the past year.
- Children needing isolation were cared for in single rooms, and we saw appropriate infection protocols being observed by staff.

Environment and equipment

Jack's Place

- Jack's Place was secure from unauthorised persons, and access was restricted by entry phone and/or swipe cards only. However, the design of the ward meant that many areas were not observable from the nurses' station or the reception desk, which posed a safety risk when children were playing in the ward.
- We observed a number of safety issues: some electrical equipment did not have PAT testing dates, and trust records showed that on the children's ward, 24% of equipment had passed their due date for servicing.
- Not all equipment in the ward was on the trust's asset register, which was why service dates had been overlooked. Staff on the ward were unclear as to whose responsibility it was to report overdue service times.
- The ward appeared clean, but it was cluttered, which meant that thorough cleaning could not be achieved. Cleanliness audits were carried out by the contracted cleaning agency, not by nursing staff.
- For equipment that nurses cleaned, we were told that the healthcare assistant kept a cleaning diary, but this could not be found. No 'clinically clean' tags were in use on the ward, and staff seemed uncertain when cleaning took place.
- The treatment room and store room doors on the ward were left open, potentially allowing access to children.
- On the day of our visit there were blood samples on a shelf in the open area of Jack's Place awaiting collection, because the pneumatic tube system to take samples to the laboratory was out of order. Children could have had access to these.
- Toys appeared clean and in good condition, but there was no cleaning schedule seen for these.
- The single rooms in the corridor section felt isolated from the main ward.

Neonatal unit

- The unit was secure from unauthorised persons, and access was restricted by entry phone and/or swipe cards only.
- The nursery areas were all clean.
- The unit was equipped with essential items to support the care and treatment of infants.
- We noted that a fridge in the neonatal unit was iced up, and there were gaps in the temperature recording. The temperature readings on several days exceeded the

recommended range of 2-8 degrees Celsius, but no action appeared to have been taken. Furthermore, the fridge contained an out of date blood sample dated 2012.

Chaucer Unit

- This unit appeared clean and uncluttered.
- Some cleaned items were marked with white laminate labels on which the date was written. This system appeared unique to the day care unit. It was not used in the adjacent children's ward.

Medicines

- There were appropriate arrangements for the safe storage of medicines. Evidence from children's medical records showed that medicines were given appropriately.
- The correct procedures were used for checking and recording the use of controlled drugs.
- Following a serious incident, there was increased attention paid to identifying allergies before prescribing drugs. However, we noted that on 20 May 2014, four out of 17 patients had not had the allergy question answered.

Records

- We were told that children were risk assessed on admission, but this was not always recorded in their notes.
- Care plans were updated regularly, although we noted that pain scores were not always recorded.
- Observation charts were fully completed.
- Admission booking, notes collation, discharge and appointments were all carried out by a ward clerk. However, as there was no ward clerk in place at weekends or on bank holidays, not all information was fully recorded at these times.
- We were told that there were delays in discharge letters for children being sent to their GPs.

Consent

- Parental consent was recorded on all the children's notes we reviewed.
- Older children told us that they were involved in discussions about their treatment, and gave their own consent, along with their parent. This was documented.

Safeguarding

- Staff we spoke with could describe the referral process for alleged or suspected child abuse, and knew the names of safeguarding leads. A paediatrician was the named doctor for safeguarding.
- Sufficient staff were trained to level 3 in child protection in Jacks Place.
- We saw evidence that the computer system flagged up children known to social services. A sticker was used on paper notes prompting consideration of potential safeguarding issues, such as unexplained delay in seeking treatment.
- Child protection issues were flagged on handover sheets.
- The named doctor for safeguarding ran peer review meetings on alternate weeks to review child protection cases.
- Staff on the wards and outpatients told us that they had up-to-date training in paediatric basic life support (PBLS) and in safeguarding.
- Only 26% of staff in the neonatal unit had level 3 safeguarding for children.

Mandatory training

- Completion of mandatory training averaged 56% across children's services. It was particularly low in the neonatal unit.
- Jack's Place averaged 83% for completion of mandatory training, but only 21% were up to date on infection control training. This was a concern as cleaning tasks by nurses required improvement.
- One nurse reported that they had had only one training day outside the mandatory training in three years.
- There was a paediatric resuscitation officer, and we were told that there was a good take up of training on paediatric intermediate life support and advanced life support.

Assessing and responding to patient risk

- Risks were discussed at monthly meetings, and lessons learned were recorded in the minutes.
- Paediatric early warning scores were used to assess the state of children's health, and enabled nurses to escalate concerns if the patient's condition deteriorated. We saw completed observation charts in children's records.

Services for children and young people

Nursing staffing

- We were told that there had been staffing issues in the past, particularly in the day surgery unit. We also noted that the children's ward had employed a number of agency staff in the previous month.
- However, there were sufficient suitably skilled nurses on the children's wards, although agency staff were needed to achieve adequate nursing levels. Two nursing staff vacancies had just been filled.
- Unexpected staff absences were filled using paediatric-trained bank staff as far as possible. We noted that there had been 49 agency shifts in April 2014 in Jack's Place.
- Where a child needed one-to-one care, additional staff were booked.
- There were concerns about recruitment and retention of neonatal nurses. The age profile of the neonatal nurses in post meant that a high proportion of them were nearing retirement.
- If there were children needing high dependency care, the number of nursing staff was increased, so that the ratio would be one nurse to two children.

Medical staffing

- There were sufficient suitably skilled doctors; however, there were concerns about an expected reduction in the number of trainee doctors, which would impact on staffing levels.
- Paediatric ward rounds took place daily, including weekends, and included surgical patients.
- There was appropriate cover from junior and middle grade doctors on the children's wards, during the day and at night.
- We observed effective and thorough handovers by doctors and by nurses on both the neonatal unit and Jack's Place. The handovers between doctors and between nurses took place at different times.
- The neonatal unit had four consultants, of whom two were locums. There were two part-time, short-term locums also working in the department while a consultant post was being advertised. Five consultants were needed to cover the unit safely. The consultants were supported by seven neonatal middle grade doctors and seven neonatal junior doctors.
- The neonatal team kept in daily contact with the maternity unit, to determine if there were any potential admissions.
- Day surgery was provided by surgeons, anaesthetists and nurses, who all specialised in paediatrics.

Are services for children and young people effective?

Good

Care and treatment was evidence-based, and delivered in line with national standards. The service took part in a number of national audits for which we saw the results. Following the recent recruitment and the filling of vacancies, there was now an appropriate skill mix of staff on the ward and day care unit.

There was strong multidisciplinary working, involving community nurses and therapy staff. Junior doctors said that there were regular training sessions.

Evidence-based care and treatment

- Children and young people's needs were assessed, and care and treatment was delivered in line with nationally-recommended guidance, such as NICE guidelines and evidence-based practice.
- The guidelines for treating childhood illnesses were found to be up to date.
- Staff knew where to find policies and local guidelines, on the intranet, and in hard copy.
- The hospital carried out local audits on various topics, including pain in children and infection screening of patients for surgery. We noted that that there had been improvements over time.
- Examples of the good practice noted in the neonatal unit included oxygen saturation measurement as part of new born baby checks, the use of probiotics, and the use of end tidal CO2 in intubation.
- Transitional care was evolving, staffed by the neonatal unit, and was thought to be an effective initiative to help mothers adjust to their babies leaving the special care baby unit.

Pain relief

- Three children told us that staff asked them about their pain, and said that they had felt better after they had been given analgesics. Not all children's notes recorded a pain score or a review post-analgesia. We were shown a paediatric pain assessment chart, but did not see this being used in the children's notes we reviewed.

Services for children and young people

- The hospital had an acute and chronic pain team that also worked with children. We saw pain control protocols for patients with sickle cell disease.
- We did not see a pain management protocol to monitor or treat pain in neonates, but observed that staff used sucrose or breast milk to calm babies. Baby massage was also used by staff to relieve pain in neonates.

Nutrition and hydration

- Children we spoke with were content with the hospital food.
- We noted that one child in Jack's Place had not been referred to a dietician, despite having allergies to two food groups.

Patient outcomes

- An audit showed that about 26 children a month needed short periods of high dependency care in Jack's Place. There was a designated area for such cases.
- Postnatal neonatal readmissions were 0.12%. This was lower than the national figure.
- The service took part in national clinical audits to benchmark its performance, including the national paediatric audits on diabetes, epilepsy, asthma and pneumonia, and the neonatal audit programme (NNAP). The asthma audit showed that care at Northwick Park Hospital was comparable with care nationally, and that there was less unnecessary intervention and better discharge planning than previously.

Competent staff

- All staff on the children's' ward and neonatal unit had appropriate neonatal or paediatric training. Staff reported that training was high quality.
- Junior doctors reported very good training in paediatrics. We noted that the current programme of lectures for doctors was wide ranging, and drew on expertise from outside the hospital.
- Medical staff felt well supported by each other.

Multidisciplinary working

- We saw evidence of regular multidisciplinary team (MDT) meetings taking place in the children's ward. Discussions involved pharmacists, physiotherapists, speech and language therapists, dieticians and clinical nurse practitioners, as appropriate. There was a weekly child protection MDT meeting.
- Every Tuesday, there were psychosocial meetings designed to prevent problems, as well as to respond to particular concerns.
- Specialist leads for child protection and bereavement provided advice and support as appropriate, and social workers were involved as necessary. There were no social workers who were based on site.
- Referrals were made to other hospitals where necessary within the London North West Newborn Network.
- Complex paediatric cases and all under 5s were referred to specialist hospitals, particularly Chelsea and Westminster, St Mary's and Great Ormond Street.
- Registered mental health nurses were always obtained from agencies if required for patients in Jack's Place.
- Child and adolescent mental health services (CAMHS) provision, provided by the local mental health NHS Trust, was unsatisfactory. Young people were only seen by CAMHS on the day of admission if a referral had been made by 11am. There was no out-of-hours cover. The result was that medically-stable children had to be supervised by agency registered mental health nurses brought in for the purpose, and this blocked a bed until they were seen by CAMHS. This was not in the best interests of the young person or the ward. Paediatricians had raised this concern with the relevant authority.

Seven-day services

- The children's service was consultant-led, with consultants on site on weekdays and at weekends. They conducted ward rounds seven days a week. A consultant was on site on weekday evenings from 6pm to 8pm, and then on call until 8am. At weekends, a consultant was on site 8am to 2pm, and then on-call thereafter.

Are services for children and young people caring?

Good

Parents and children said that the service was caring, and that their needs for information and support were met. We observed good interaction from medical staff and nurses with patients and their families. Clear explanations enabled families to be involved in the care of their children and in decision-making.

Services for children and young people

We saw good evidence of practical and emotional support for families.

Compassionate care

- Staff treated children in a kind and reassuring manner. Children told us that the nurses were friendly and helpful, and responded quickly to their call buzzers.
- Relatives felt staff generally kept them well informed.
- One parent was able to stay overnight with their child in Jack's Place.
- Lots of thank you cards showed that parents and children appreciated the service.

Patient understanding and involvement

- All the children and young people we spoke with said that nurses offered them choices and explained what they were doing.
- Older children said that they were involved in their care plans.
- The hospital provided child-friendly information about conditions; we saw a child using a fun exercise book about living with diabetes.
- The children's units produced clear information for parents; there was general information about the ward, day surgery procedures, general anaesthesia and procedure-specific leaflets, such as adenotonsillectomy advice.
- Parents of children coming to clinics for diagnostic tests were sent written information about tests. They were also given written information about chronic conditions. Parents said that they had been given time to talk to staff about how to support their child during their illness.
- Parents and carers were kept informed if there was a delay to their child's treatment.

Emotional support

- Families were supported by community nurses and consultants in the event of a death. When babies died, memory boxes were available that included photographs and foot and handprints. If parents did not want these immediately, the hospital kept them with the baby's notes in case they were requested for them later.
- There was also debriefing for staff following child or baby deaths.
- Parents of inpatients were able to discuss any concerns with the consultant responsible for their child.

Are services for children and young people responsive?

Good

There were arrangements to meet the diverse language needs of the population served by the hospital, using a contracted provider and interpreters. There were leaflets for families in a variety of languages. Some appointments were made by telephone using the contracted interpreting service rather than by letter, as this improved attendance at outpatient appointments.

Discharge planning meetings took place, and involved the family, as well as community services, to ensure that the right support was available at home. There were no processes to obtain the views of the service from families and friends, although we were told that some ideas were being considered.

Service planning and delivery to meet the needs of local people

- GPs were able to refer children to urgent-access clinics, which ran three times a week.

Access and flow

- There was a steady flow of patients to the children's ward, both day cases and inpatients, and we were told that the ward occupancy rate was around 80%.
- Admissions to the ward came under the consultant on duty that week, unless the child was already known to another consultant.
- In outpatients, waiting times were fairly short.
- Parents were given information on the discharge of their child, and an outpatient appointment referral to community nursing was made, if required.
- Parents we spoke with were involved in the plans for their child's discharge, and felt well informed about how to look after their child at home.
- The neonatal unit had a small outreach team in the community, which supported parents with caring for their baby.

Meeting people's individual needs

- Interpreters could be arranged where children or their families required this.
- There was a lounge for adolescents in Jack's Place, so they could be separate from younger children.

- The local authority no longer provided tuition to children whilst they were in hospital, so parents had to contact their children's schools to make tuition arrangements.
- Children who had been inpatients were sometimes asked to come back for a review on the ward, but there was no direct referral to the ward. Children had to be admitted through A&E.
- Volunteers provided professional help, through a support group for families whose babies had been in the neonatal unit.
- We heard about good practice in end of life care. There was contact with a palliative care nurse from Great Ormond Street, a quiet room for families, involvement with local child hospices and access to counselling.
- Staff told us that families will often use their own spiritual leader for emotional support, although the hospital offered Christian, Hindu, Muslim and Jewish chaplaincy services, and had contact numbers for other faith groups.

Learning from complaints and concerns

- Information was displayed at outpatient clinics on how people could provide feedback on the service they had received, and how they could make a complaint.
- Complaints were followed up in discussions with families. We saw a recent example of this, and the incident in question was to be used in the training of staff.

Are services for children and young people well-led?

Requires improvement

There were developments in motion to improve care, which were focused around the merger with Ealing Hospital NHS Trust. However, it was also clear that the prospect of the merger had created uncertainties for staff, which may have affected their support for change. There was a lack of joined-up working across the medical team, and between doctors and nurses.

The children's service had its own governance arrangements. However, the service itself was distant from the board. Most staff were not able to tell us who spoke for children's services at board member level.

Children's services learned from incidents and from audits to improve care. However, the failure to engage patients and families in service improvement was a barrier to developing a service to meet patient needs as effectively as possible.

Vision and strategy for this service

- The planned merger with Ealing Hospital NHS Trust had provided a focus for refreshing the vision for delivering children's services and for continuing to reconfigure the service.
- The high level vision was to provide safe, high quality, patient-centred, generalist services for babies, children and young people, through integrated acute and community services. Representatives from across the service had been involved in developing this vision, which was published in October 2013. However, we did not gain the impression that the consultants were fully united around this vision.
- The neonatal unit took part in the baby friendly (UNICEF) scheme to support breastfeeding and strengthen mother, baby and family relationships. It had achieved level 3.

Governance, risk management and quality measurement

- Paediatric clinical governance meetings covered learning from serious incidents elsewhere in the trust. They also included learning from complaints, discussion of cases, feedback from incidents and reviewing audits.
- A number of local and national audits took place in order to measure quality.

Leadership of service

- We were told that there were some tensions between medical staff, and they did not function as a leadership team for the service as a whole.
- The matron for Jack's Place also had responsibility for the outpatient clinic at Northwick Park Hospital (Chaucer).
- Consultants held weekly meetings to review the care in Jack's Place, but nurses did not always attend.
- Staff on the neonatal unit held weekly business meetings that were minuted, with actions for named individuals.
- There was an annual session for staff on major incident awareness, and a major accident plan had been drawn up two years ago.

Services for children and young people

Culture within the service

- Nurses considered the culture in the children's service to be open, and stated that there was no blame attached to reporting incidents.
- Junior doctors said that consultants were supportive and that there was a well-run teaching programme.

Public and staff engagement

- The children's services did not use Friends and Family Tests, and there were no formal processes to obtain the views of families, children and young people. We were told that staff were working on ways of seeking feedback, but we did not see any documents to support this.

Innovation, improvement and sustainability

- A good example of innovation was the jointly-created integrated care plan for asthma care, developed with GPs. This had been shown to reduce A&E attendance by half, and reduced admissions by one third.
- A project to recognise levels of pain in non-communicating children had been piloted with a primary special school, and further work was taking place to explore its use with secondary school pupils.
- The neonatal unit has been very effective in raising breastfeeding rates.

End of life care

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

Information about the service

Palliative care is provided for all the hospitals in the North West London Hospitals NHS Trust by the specialist palliative care team (SPCT) based in the Macmillan Unit at St Mark's Hospital. Specialist palliative care is advised for patients who are suffering with advanced symptomatic disease, or who are no longer suitable candidates for curative oncological intervention.

During our inspection we spoke with a number of nurses, junior doctors and consultants on several wards. We spoke with the lead consultant and lead nurse for palliative care, four specialist palliative care nurses, the lead oncology nurse, the bereavement officer, chaplain, a mortuary technician, two porters, a volunteer and two staff from the Macmillan support services. We reviewed records, policy documents, meeting minutes, audit results, the specialist palliative care patient survey and 'thank you' cards. Due to the sensitivity of the patients receiving end of life care at the time of our visit, it was not appropriate to speak to them, or their relatives and friends, about the care they were receiving.

Summary of findings

We found that the end of life care to patients was good overall. The hospital had good links with the SPCT and community services, in order to support patients and their families. The SPCT and other services involved in end of life care were passionate, caring and maintained patients' dignity throughout their care. There was clear multidisciplinary involvement in patient care. Patients were involved in advance care planning, and their preferences were observed and followed through when possible and appropriate. People's cultural and religious needs were taken into account.

Staff hoped that the recent appointment of a non-executive director lead in end of life care would increase the department's visibility with the board. End of life care training was not mandatory within the trust, and this meant that healthcare professionals at the hospital found it difficult to attend the courses provided by the SPCT. The SPCT were researching into how to provide an integrated care pathway that involved community services such as nursing, palliative care, GPs, ambulance, hospices and care homes, to frail and older patients, and those dying through complex health issues. It is hoped that this would also decrease the number of unnecessary admissions to the hospital.

End of life care

Are end of life care services safe?

Good

Staff were expected to report all incidents, and they told us that they would always report incidents relating to patient safety. However, they did not always have time to report all incidents, due to work pressures, or due to difficulties with the electronic reporting system.

The records we reviewed were found to be appropriately completed, and medicines were appropriately prescribed. Staff understood how to safeguard patients from abuse. They were aware of the Mental Capacity Act, and what to do if someone was unable to give informed consent.

Incidents

- There were no 'never events' or incidents reported to the National Reporting and Learning System (NRLS) relating to end of life care.
- Staff were expected to report incidents through an electronic incident reporting system. All staff members we spoke with told us that they would report incidents, relating to a patient's immediate safety, on the electronic incident reporting system. However, they told us that they did not always report other non-patient safety incidents, such as a delay in a patient receiving medication, through the electronic reporting system. They did say however, that they would report such incidents immediately to the most senior member of staff on duty at the time.
- Staff told us that although the electronic incident reporting system was straightforward, it did not allow them to save a report if it had not been fully completed. The SPCT worked across the whole of the hospital, which meant they may not have all the details relating to the incident to hand (such as names of people present at the time of the incident). In such circumstances, it would rely on them going back to the ward to get the details, which was sometimes difficult after the event. Other reasons for not reporting incidents on the electronic system included a lack of time and a lack of feedback after incidents had been reported.

Safety monitoring

- The clinical audit marginally fell below the national average in two areas. The trust scored 57% for multidisciplinary team (MDT) recognition that a patient was dying (nationally 59% was achieved); and 48% for medication prescribed when necessary for the five key symptoms (nationally 50% was achieved).
- The trust scored above average in all other areas of the clinical audit, which included nutrition, hydration, spiritual needs, discussions with the next of kin that the patient was dying, plan of care for the dying phase and care after death.

Medicines

- The records we looked at showed that patients whose condition could deteriorate required medicine to alleviate their symptoms. Arrangements were in place to ensure that medicines had been prescribed in advance, so that patient's waiting time and discomfort were minimised.
- There was a medicines support team on the wards for older people. They liaised with GPs, social services and the palliative care team to ensure that people received appropriate care once they were discharged from the hospital. Patient's prescription charts showed that they had been prescribed appropriate medicines for palliative care, which included pain relief and anticipatory medicines, such as medicines for nausea and vomiting.
- The palliative care team provided patients who were returning to their home with a supply of their medication and a leaflet listing the medicines that they were taking.
- Some patients received palliative chemotherapy to support their symptoms. There was good multidisciplinary working between the chemotherapy day unit at St Mark's Hospital and the pharmacy department, to ensure that patients received their treatment without unnecessary delay.
- Electronic prescribing was in place for colorectal and lung cancer clinics. This meant that information was easily available to all departments to ensure that drug treatments were prepared by the pharmacy on time.
- There were plans to roll out electronic prescribing to other clinics, as we were told that sharing paper-based information, such as blood test results between departments, had the potential to cause delays in the preparation of drug treatment. The unit kept supplies of supportive treatments, such as anti-emetics, to avoid

having to send unwell patients to the pharmacy department, and there was good liaison between the unit and the palliative care and community nursing teams.
- Patients receiving chemotherapy on the wards were supported by staff from the day unit.
- We were told that some patients had experienced problems receiving their treatment in the community, because in some areas, community nurses required an authorisation from the GP to administer certain medicines.

Records
- Patients receiving end of life care who had been identified as 'not for resuscitation' had paperwork visible in their notes so that staff were aware of what actions to take.
- We looked at a sample of 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms across a number of wards throughout the hospital. We found that they were completed appropriately and relatives' involvement was recorded. However, the SPCT reported that not all DNACPR forms were completed correctly or completely, and they challenged staff where they found incomplete forms.
- The SPCT provided patients who were discharged to their home/care home/hospice with an information pack on how to support someone who was dying at home. This included information regarding a person's choice relating to being resuscitated and who had been involved in the discussions. However, we found that the information regarding discussions relating to DNACPR was confusing, as it was not clear as to whether the person wished to be resuscitated or not. This was pointed out to the team, and they planned to change the information immediately to make it clearer for people who may be reading it for the first time.
- The SPCT told us that records completed by the referring healthcare professional were often lacking in information about the patient, which meant that the clinical nurse specialist (CNS) had to make further enquiries to ascertain how quickly the patient needed to be seen.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
- The trust had a policy and procedure to identify patients who were lacking capacity to make decisions about their care. This was accessible to all staff on the organisation's intranet.
- Best interest multidisciplinary team (MDT) meetings, which involved the clinical staff and palliative care team responsible for the patient's care, took place every week.
- The next of kin/advocate was involved in decisions relating to the care for a patient who could no longer make decisions for themselves.

Safeguarding
- All staff were trained in safeguarding vulnerable adults and children as part of their mandatory training. They could access the trust policy and procedure through the internal intranet system.
- Macmillan staff told us that they would refer someone who appeared to be at risk of harming themselves, which could be as a result of receiving bad news, to the mental health team or their doctor to follow up.

Mandatory training
- All nursing and clinical staff had completed their mandatory training.

Assessing and responding to patient risk
- The SPCT told us that they would not expect to be asked to attend to every patient who was dying in the hospital, as many of the consultants at the hospital responded appropriately when a patient's condition was deteriorating.
- New patients and urgent cases referred to the SPCT were prioritised and discussed at weekly MDT meetings.
- The ward staff we spoke with were aware of the palliative care team and requested their support if they recognised that a patient's condition was deteriorating or if they needed reassurance that an appropriate course of action was being taken. However, the SPCT reported that some medical staff did not agree with the advice that the clinical nurse specialist (CNS) gave and would, on occasions, continue with a course of curative treatment when a patient was in the latter stages of dying.
- The SPCT checked with nursing and medical staff as to whether a patient had responded to any changes to their treatment.

End of life care

Nursing staffing

- The end of life team was mainly nurse-led. It consisted of four and a half full-time CNS, including the lead CNS, and a MDT co-ordinator.
- Some team members were supported and funded by Macmillan. The Macmillan team were not easily identifiable as they did not wear anything to indicate this. We were told by the SPCT that some patients were expecting Macmillan staff to support them and did not identify with the SPCT.
- The bereavement officer was a qualified nurse, and this meant they were able to answer some of the questions that the relatives of the deceased might have about the care and treatment the patient had received, as well as help them to understand the death certificate and cause of death.

Medical staffing

- There were three consultants including the lead clinician. Each consultant worked within the SPCT for one session (0.5 day) per week. The remainder of the time they worked across the hospitals in the trust. This allowed them to have a wide perspective of the patients within the hospital and areas where palliative care was required.

Extended Team

- Oncology support and advice was available from staff running the Macmillan kiosk in the main entrance of the hospital.

Are end of life care services effective?

Good

The trust was still using some elements of the Liverpool Care Pathway (LCP) while they reviewed their procedures for the care of a dying patient as recommended by an independent review and following recommendation to phase out the LCP. The team also referred to the London Cancer Alliance for further guidelines.

We looked at a sample of patient records and saw that they received appropriate pain relief, nutrition and hydration. Staff were appropriately trained and supported, and there were regular multidisciplinary meetings.

Evidence-based care and treatment

- Following the independent review of the use of the LCP for the Dying Patient, and the subsequent announcement of the phasing out of use of the LCP, the trust had made some interim amendments, which included the removal of direct and indirect references to the LCP. An essence of the LCP was still in place, as the staff had found that the assessment tools were useful.
- The trust policy and procedure was under review, and there was a steering group reviewing the recommendations to replace the LCP.
- The team referred to the London Cancer Alliance (LCA) for further guidelines..

Pain relief

- The patients we reviewed received appropriate pain relief.

Nutrition and hydration

- The patients we reviewed received appropriate nutrition and hydration.

Patient outcomes

- The trust took part in the National Care of the Dying Audit for Hospitals (NCDAH). The audit is made up of an organisational assessment and a clinical audit. The trust achieved four out of the seven key performance indicators (KPI) in the organisation audit, and seven out of ten for the clinical audit.
- The SPCT had analysed the main findings of the audit and proposed a number of recommendations to improve the service provided.
- The trust opted out of the bereavement audit summary as a majority of patients' notes did not contain the next of kin details, so they were unable to obtain bereaved relatives views.
- The SPCT had good links with the community palliative care team, so that patients could receive continued support within the community.

Competent staff

- All nursing staff had annual appraisals on their performance with their manager.
- Staff had a supervision meeting with their manager once every six months.
- The CNS and consultants were required to complete continuing professional development courses, and they attended various other courses relating to their role in end of life care.

End of life care

- The team had increased their profile with the trust; however, this had led to an increased referral rate across the trust, from 450 in 2012 to 1,000 in 2013. Staff resources were stretched, as their workload had doubled and the staff numbers had remained the same.
- End of life training was offered by the SPCT to all staff within the trust. However, this was not currently mandatory as recommended nationally. The training included: communication training, how to have difficult conversations, identifying the signs of dying and policies on syringe drivers.
- The SPCT team told us that it was difficult to engage junior doctors and consultants in the training, and nursing staff found it hard to attend due to work pressures. 25% of staff had undertaken training.
- Portering services were provided by a private company. The bereavement officer had identified a need for the porters to be trained in dignity around bereavement and transportation of bodies. 75% of the porters had received an in-house training course. They reported that the course was very useful, and had given them confidence and pride in their work. One porter told us how their knowledge had meant that they were able to challenge a member of ward staff with regard to incorrect identification being attached to a body.
- Some of the SPCT CNS's were studying for a qualification to become a nurse prescriber. This would mean that they would be able to prescribe appropriate medicines, as well as advise on them.
- The bereavement office assisted junior doctors on how to fill out the medical certificate of death, in order to prevent the registry office rejecting them for being completed incorrectly. This meant that distress to families would be minimised.

Multidisciplinary working

- Multidisciplinary palliative care meetings were held weekly. New and complex cases were discussed. We were told that the chaplaincy team were invited to these meetings, but rarely attended. The chaplaincy told us that they were unaware that they were invited to attend the meetings.
- The extended multidisciplinary team members were invited to attend the end of life team's annual operational meeting, so that they could to agree to its operational policy.

Seven-day services

- The SPCT was available at the hospital from 9am to 5pm from Monday to Saturday.
- Out-of-hours support services were provided by Michael Sobell Hospice at Mount Vernon Hospital.

Are end of life care services caring?

Good

During our inspection we did not speak with any patients or their families/friends about the end of life care services, as it was a sensitive time for people, and it was felt that it was not appropriate to intrude on their circumstances. We observed staff treating people with compassion, dignity and respect. Other staff were able to explain how they cared for and supported people.

Records showed patients and their families were involved in discussions relating to their care. A named ward nurse was allocated to patients for continuity of care. There were other support services available, such as a multi-faith chaplaincy and Macmillan cancer care services.

Compassionate care

- During our inspection we saw patients being treated with compassion, dignity and respect. 'Thank you' letters showed how much patients and their families valued the support, advice and care that the SPCT gave to them.
- Staff spoke passionately about how they cared and supported people.
- Normal visiting times were waived for relatives of patients who were at the end of their life.
- The SPCT told us that they encouraged ward staff to sit with patients who did not have regular visitors at the end of their life.
- If appropriate, a patient was moved to a side room to offer more privacy when they were nearing the end of their life. If this was not possible, curtains were drawn around their beds.
- Deceased patients were moved from the ward to the mortuary as soon as was practicable. We saw porters handle bodies with care and dignity while transporting them to the mortuary.

Patient understanding and involvement

- Patients were given a named nurse on the wards.

End of life care

- The clinical nurse specialists (CNS's) were not allocated to individual patients as they were required to support a number of patients over all the hospitals. The team tried to ensure that no more than two CNS supported one patient in order to maintain continuity in their care.
- Patient records that we viewed showed that the conversations regarding end of life care, which had taken place between healthcare professionals, patients and their families, were recorded.

Emotional support

- CNS supported patients and their relatives. People were given as much time as they needed to talk about their thoughts and feelings.
- Macmillan staff were available at the hospital, and provided support to friends and relatives.
- Patients had assessments for anxiety and depression, and appropriate clinical support was offered.
- A psychotherapist was available for bereaved parents on the neonatal ward.
- Multi-faith chaplaincy was available, if required, to provide spiritual support.
- The bereavement officer supported relatives/friends after the patient's death by explaining all the legal processes, and what to expect after someone has died. They provided an information pack which included the contact details for support and counselling groups.
- Parents of miscarried babies were offered a funeral service in the hospital chapel. The bereavement officer told us that many of the parents found this support valuable, as it gave them an opportunity to share their experience with other people, and allowed them to grieve for their child. The hospital could also arrange for their babies to be cremated and for them to have the ashes.

Are end of life care services responsive?

Good

Overall we found the end of life care service to be responsive to people's needs. It had been identified by the SPCT and the NCDAH that some staff did not recognise the stages of dying, which meant that some patients may continue to receive curative medicines which might not be appropriate. However, the number of patients referred by healthcare professionals to the SPCT had doubled in the last year, which meant that more staff were recognising the signs of a deteriorating patient.

Most wards/departments did not have an adequate room where sensitive conversations could be held with families. However, patients coming to the end of their life were moved into side rooms if appropriate, in order to allow privacy.

Service planning and delivery to meet the needs of local people

- The SPCT knew how many patients they were supporting with end of life care. However, we were not able to identify how many patients in the entire hospital were receiving end of life care with support from the ward staff and their consultant.
- The SPCT profile had increased over the last year and their workload had doubled, as more staff referred patients to them. However, the team size had remained the same. The staff reported that this meant they were often completing reports in their own time at the end of their shift to allow them enough time to spend with patients and their families.

Access and flow

- Patients whose condition was identified as deteriorating could be referred to the SPCT by any healthcare professional in the trust. The community palliative care team could refer patients to be admitted to the hospital.
- Based on figures from the period September 2012 to the end of February 2013, on average half of the patients referred to the SPCT were referred by doctors, the remaining half were referred by ward staff and specialist nurses.
- Hospital staff had access to an electronic co-ordination system to refer patients to the SPCT.
- 60% of patients were receiving palliative care for cancer-related illness; 40% were non-cancer related.
- Patients were seen by a CNS within 24 hours of referral for urgent cases, and within three days for non-urgent cases. We saw that all referred patients had been seen within the relevant time scales.
- Patients who had a terminal illness were supported in being discharged to a place of their choice. This could be achieved within 24 hours if all the relevant assessments and community resources were readily accessible. The CNS administered the discharge for

anyone under their care. This was a lengthy process and could take them up to five or six hours. This meant they were taken away from spending time with other patients. The CNS we spoke with told us that they would value administrative support to assist them with discharges and allow them more time with patients.

Meeting people's individual needs

- The SPCT had identified that some healthcare professionals did not always recognise the early stages of dying and therefore, on occasions, continued with curative treatment when it was not appropriate.
- Interpreters were available for people who were unable to understand English.
- A multi-faith chaplaincy was available. There were full-time Church of England and Catholic priests, and part-time Muslim, Jewish and Hindu spiritual leaders available.
- The hospital did not have a bariatric trolley at the time of our inspection. However, staff had identified a way of transferring bodies too large for the usual mortuary trolley which retained the dignity of the deceased.
- We were shown a breakdown of where people wished to die against the number who actually died in their preferred place. However, this had not been fully completed since February 2013. The six months prior to that showed that the majority of people did not die in their preferred place. We were unable to ascertain the reason for this.
- The bereavement and mortuary services took into account people's religious customs and beliefs, and were flexible around people's needs. An example of this was where a family did not wish for their relative's body to be taken to the mortuary, so it was arranged for the body to lie in the chapel of rest until the funeral director arrived that day.
- We were told that a terminally ill mother could be cared for alongside her baby.
- The trust did not achieve 'providing specialist support for care in the last hours or days of a person's life'. This was because they did not provide face-to-face specialist palliative care services from 9am to 5pm, seven days a week, although there is a national recommendation that this should be provided. Nationally, 21% of trusts achieved this. However, there was access to a telephone helpline out of hours.

Learning from complaints and concerns

- Complaints were monitored by the lead CNS. Any learning and patterns were identified and discussed at the team meetings. The SPCT had received three complaints in the last year, and they had all been investigated appropriately by the complaints department.
- Across the entire trust, the chaplaincy ran a multi-faith user group, where they discussed patient care. One concern raised was related to staff not being aware of religious days or festivals for different faiths. As a result of this, a multi-faith calendar was produced and placed in multiple locations within the hospital. This meant that staff could support patients with their faith. Patients reported to the chaplaincy that they appreciated the staff's knowledge of when religious events took place. However, we noted that the calendar did not indicate what was required on the given day, such as wearing particular clothing or fasting times, so staff were not made aware of what the event meant to the individuals to whom it related.

Facilities for relatives/carers

- Most of the adult wards did not have an adequate space where staff could talk with relatives privately, or for relatives to have some personal time away from the ward. The staff used clinic rooms on the wards when they were required to speak to people about more sensitive issues. There was a separate lounge area for this purpose on the children's ward.
- The A&E quiet room was used for relatives/friends to spend time with the deceased patient, or to discuss sensitive issues. This was a not an ideal environment, as you could see ambulances regularly arriving outside the window.
- The bereavement office provided comfortable seating, and the bereavement officer had personally provided some home furnishings to make the environment feel less clinical.
- There was a bed available for a parent to use while staying with their child on the children's ward.
- There was a multi-faith chapel and prayer room.

End of life care

Are end of life care services well-led?

Good

We found that overall, the end of life care services were well-led. The trust had recently appointed a non-executive director to lead on end of life care. It was too early to say if this would raise the profile of the service at board level and increase the focus on providing good end of life care for every patient within the trust.

We found strong positive leadership across all the services involved in end of life care. All staff were passionate about their work in supporting and caring for patients and their families. Patients, their families and staff were asked for their views of the service. The SPCT were undertaking a number of research programmes to find ways to reduce the number of unnecessary hospital visits for patients nearing the end of their life.

Vision and strategy for this service

- The end of life team had an annual general meeting where they discussed and agreed their operational policy, and work plans and priorities for the following year. This included the Macmillan, bereavement and chaplaincy services.

Governance, risk management and quality measurement

- Palliative care and oncology clinical governance meetings took place every three months.
- MDT team meetings took place every week. Complaints, concerns or issues were raised, discussed and planned for.
- The clinical lead told us that the MDT relationship was not as robust as it could be, and they were in the process of establishing a more integrated model of working to include the hospital discharge teams and community services.

Leadership of service

- Many of the staff we spoke with said that they would not know the executive board members and had not seen them on the wards engaging with staff and patients.
- The trust had recently appointed a non-executive director to lead in end of life care. The lead clinician and CNS spoke positively of this appointment, and felt that the future would be positive. However, it was too early to say whether this would increase the profile of end of life care within the trust.
- The lead clinician and lead CNS were responsible for the day-to-day running of the team. They were very energetic and had a positive vision for end of life care within the trust.
- All the CNS felt supported by the management team, and shared in the department's vision to provide a caring and responsive approach for people requiring palliative care.
- The management team and staff all agreed on the challenges and pressures they faced.
- The bereavement officer was well respected by colleagues, and supported doctors, porters, the chaplaincy and mortuary staff through a very professional approach.

Culture within the service

- Most of the staff we spoke with were unsure of the future of the hospital and what it would mean for their role. They all felt that any progression had been put on hold due to the merger plans.
- Staff we spoke with in relation to end of life care spoke positively and passionately about the work they did in supporting patients approaching the end of their life, and supporting the family and friends during and after the patient's death.
- The SPCT, chemotherapy day unit, Macmillan support services and pharmacy team worked closely together, and supported each other in ways to improve the patient's experience. This was paralleled by the bereavement office, mortuary and chaplaincy.
- Most of the staff we spoke with on the wards were aware of the SPCT. However, many of them were not aware of the training that the team offered.
- Staff reported that it was difficult to be released from the wards to participate in extra training as work pressures often prevented them from attending voluntary courses.
- Staff told us that it was difficult to engage junior doctors and consultants in end of life care training.
- The CNS within the SPCT felt involved and supported in putting forward any ideas they had to improve the service they offered.

End of life care

Public and staff engagement

- Relatives/friends of people who died at one of the trust's hospitals were invited to complete a survey. Between March and October 2013, 100 surveys were given out. 16 completed surveys were received. Staff told us that the return rate was probably low because they related to a very sensitive subject, which people may not want to think about.
- The department used learning outcomes from the NCDAH audit to improve their services.
- Staff told us that they would engage with people at the time if there were any concerns.
- We saw that there were a number of 'thank you' letters from relatives outlining areas of care they appreciated, such as support and comfort.
- Staff who attended courses run by the SPCT were asked their opinion of the training. A majority indicated that the courses helped them considerably in recognising a dying patient and how they could support them.

Innovation, improvement and sustainability

- The SPCT implemented a study in improving the outcomes for patients by establishing an integrated heart failure (HF) pathway. The aim of the project was to develop an integrated approach to the assessment and care of patients with advanced HF, to ensure better identification, palliation of needs and choices at the end of life. The results improved cardiac and palliative care for patients, improved the use of hospice and community services, and reduced the number of inappropriate admissions to hospital. It gained huge endorsement from community HF nurses.
- As a result of the success of this study, the SPCT secured two Darzi fellows to lead a service development programme to reduce the number of admissions to hospital for patients with long-term conditions, or who were frail in the last years of their life.

Outpatients

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

Information about the service

Northwick Park Hospital is one of three locations run by the North West London Hospitals NHS Trust, which last year provided a service to 374,000 outpatients.

There is a centralised outpatients area with a main reception. Individual clinics are run in this area, with their own reception desks. The clinics held here include endocrine, infectious diseases, neurology, respiratory, vascular surgery, haematology, diabetes, phlebotomy, dermatology, urology, trauma and orthopaedics, general surgery and oncology. Other outpatient services are run and managed elsewhere in the hospital by their own directorates. These include cardiology, medicine, care of the elderly, obstetrics and midwifery and paediatrics.

During our inspection we visited the main outpatient area and visited the clinics for haematology, dermatology, diabetes, orthopaedics and urology. We met with 18 staff including receptionists, nursing staff, healthcare assistants, consultants, administration staff and the manager of the outpatients department. We spoke with seven patients. We looked at the patient environment, and observed waiting areas and clinics in operation.

Summary of findings

Patients received compassionate care, and were treated with dignity and respect by staff. The outpatients' environment was clean, reasonably comfortable, well maintained and safe. Staff were professional and polite, and promoted a caring ethos.

Patient notes for the individual clinics were kept in open trolleys, and we saw that on occasions, these were left unsupervised. The lack of secure storage meant that there was the possibility of confidentiality being breached.

Clinicians took sufficient time in consultations, and patients said that they felt involved in their care. The demand for some of the clinics was greater than the capacity. This meant that some clinics ran late and also had long waiting times for appointments. There were initiatives in place to consider moving some services to improve their efficiency.

Outpatients

Are outpatients services safe?

Requires improvement

The patient outpatient areas were clean and well maintained. Infection control procedures were followed, and regular audits were completed. Patient notes for the individual clinics were kept in open trolleys, and we saw that on occasions, these were left unsupervised. The lack of secure storage meant that there was the possibility of confidentiality being breached. Patients were at times being seen without a full set of notes being available to the consultant in charge of the clinic.

Incidents

- There had been no 'never events' or serious incidents reported in the outpatients department.

Cleanliness, infection control and hygiene

- The main waiting area was clean and well maintained. Patients we spoke with said that the consulting rooms were clean, and staff we spoke with told us that cleanliness standards were maintained. Staff told us that if additional cleaning was required this was quickly organised.
- Regular infection control audits were completed and the reports provided to the outpatients manager.
- The toilet facilities were regularly checked and cleaned.
- 'Bare below the elbow' policies were adhered to in the clinical areas.
- Hand hygiene gel dispensers were provided in the waiting areas, and we observed these being used by patients and staff.
- Staff completed infection control training as part of their mandatory training.

Environment and equipment

- The main outpatients area had been renovated and updated in recent years, and the environment was safe. It was comfortable and well maintained.
- The resuscitation trolleys were located in one main room. We saw that the equipment was checked daily by the nursing staff, and that records were kept. The equipment was also checked regularly by the hospital's resuscitation team.
- Equipment used in the clinical areas was correctly serviced and maintained, and records were kept. Audits were completed on the servicing of equipment.

Medicines

- Medicines were stored correctly in locked cupboards or fridges where required. The cupboards were checked daily by the nursing staff, and inspections were also carried out by the pharmacy department.
- Patients we spoke with told us that they received appropriate information about the medication they were prescribed, and that changes to their medication were explained to them.
- Written information about medication was only available in English. This could mean that for some patients there could be difficulties in understanding the directions.

Records

- The patient records for each clinic were held in an open trolley. These were not lockable, and there was no lockable storage available in the clinic reception areas. Some staff moved the records into a consulting room when they had to leave the clinic desk. This was not always possible, as a room was not always available. On three occasions, we saw that a trolley of patient notes had been left unsupervised. This meant there was a possibility that patient confidentiality could be breached.
- At some of the clinics we saw that temporary notes for patients were in place. An explanation was supplied with the notes as to why the patient's full set of notes were not available. This was often due to a patient having been seen at another hospital within the previous 24 hours, and there not being enough time to transport the notes.
- Information about patients were also available electronically.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients gave their consent appropriately and correctly. Patients we spoke with told us that the clinical staff asked for their consent before commencing any examination or procedure

Safeguarding

- All nursing and other healthcare staff we spoke with confirmed that they had completed safeguarding training, and were aware of the procedure to follow should they need to report a concern.
- Information about safeguarding was displayed in several parts of the outpatients area.

Outpatients

- Patients we spoke with told us that they thought the outpatients department was a safe place to visit for treatment.

Mandatory Training

- All staff were required to complete a range of mandatory training, which included fire safety, safeguarding, moving and handling, and infection control. All the staff we spoke with told us that they had completed this training, and also any required updates. Staff were aware of their responsibility to ensure they were up to date with mandatory training.
- The manager of the outpatients department was provided with an electronic update on staff whose training was due for renewal.
- Mandatory training was checked as part of staff's annual appraisal process.

Staffing

- The main reception desk had enough staff to ensure that patients were attended to within a reasonable timescale. The clinics we visited all had their designated staffing levels in place, with the exception of the afternoon orthopaedics clinic, where one health care assistant was working. We were told that generally rotas were organised with additional cover from bank staff when required.

Are outpatients services effective?

Not sufficient evidence to rate

We report on effectiveness for outpatients below. However, we are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients.

Evidence-based care and treatment

- We were told that guidelines, such as NICE guidelines, were followed where appropriate.
- Staff were aware of how to access policies and procedures online. Nursing staff told us how new practice guidance was cascaded, either through the department, or through the specialist area in which they were working.

Patient outcomes

- Staff explained that clinics could become unexpectedly busy for a number of reasons. These included complications in a consultation, delays in getting X-rays or other test results, and additional referrals from the A&E department.

Competent staff

- Staff we spoke with told us that they had annual appraisals, and we saw that this was monitored by the manager of the department. When appraisals were due, any mandatory training that a staff member needed to complete was also highlighted to the manager.
- We spoke with two healthcare assistants. They said they had been well supported by senior and nursing staff to develop the skills they needed. Staff told us they had regular meetings with their team and supervisors.

Multidisciplinary working

- Staff told us that they thought the multidisciplinary working was effective, and that skills and knowledge were professionally shared; an example of this was the way in which a dietician supported the diabetes clinic.
- Specialist nurses supported medical staff in some clinics, such as in bariatric clinics.

Equipment and facilities

- The outpatient area had been updated and renovated in recent years, but due to the increased demand, there were times when additional clinics could not be run because there were no available rooms.

Seven-day services

- The outpatient service provided a Monday to Friday service, but additional clinics were often run on Saturdays to accommodate the increased demand.

Are outpatients services caring?

Good

We found that the main outpatients department at Northwick Park Hospital was focused on the patients. We observed staff interacting with patients in a caring and respectful manner. All the patients we spoke with told us that the staff were caring and polite.

Outpatients

Compassionate care

- We visited the main outpatients area on two separate occasions and observed staff treating patients with dignity and compassion. Staff responded to questions and queries in a positive and respectful manner.
- We saw staff apologising to patients when clinics were running late, and providing an explanation for delays.
- When all the consulting rooms were occupied, there was not always a private area for staff to discuss matters confidentially with patients and their relatives. We observed a nurse explaining this to a patient and then taking them to quiet area of the waiting room to discuss their next appointment. The nurse also offered to wait until a room became available.
- Staff told us that chaperones were always provided if required, and relatives and friends could accompany patients into a clinic if requested by patients. A consultant confirmed that the staff always provided a chaperone when this was required. Patients we spoke with were aware that chaperones were available, but there was no written information displayed in the waiting area about this service.
- Patients we spoke with told us that the staff were friendly, polite and respectful. One relative accompanying a patient told us “they are all brilliant with my mum because she can get quite nervous”.

Patient understanding and involvement

- Patients we spoke with told us that they were involved in their care. We were told that the nursing staff and consultants explained things clearly and always answered any questions. One patient told us that they had been a regular visitor for several months, attending two clinics. They told us how they had been involved in discussing changes to their medication, and also the options for future treatment of their condition.

Emotional support

- Information was displayed in the main waiting area about various support networks or groups that patients could access. Information and directions were also provided for the hospitals prayer room and chapel.
- Patients and relatives told us that they had been given sufficient support by staff when they were given information about their treatment or diagnosis.

Are outpatients services responsive?

Requires improvement

The outpatients service required improvement to deliver a responsive service to the needs of the patients. The trust had taken steps to implement an action plan to address shortfalls around meeting the 18 week referral to treatment pathways target; however there were a significant number of patients waiting over 18 weeks to be seen. Action taken included staff training, improving processes, and running additional clinics to reduce waiting times. However, some clinics were often overbooked, which meant that there were long waiting times for patients and patients had their appointments cancelled.

Service planning and delivery to meet the needs of local people

- Data supplied showed that the trust provided an average of 500 clinics a month for between 27,000 and 33,000 patients. The manager of outpatients told us that demand could outstrip capacity, leading to extended waiting times and delayed appointments.
- In February 2013, the trust identified a shortfall in the 18 week patient referral to treatment (RTT) pathway. Following an internal review action was taken by the trust. A support team from NHS England were engaged to review processes and pathways underlying the 18 week RTT.
- The team undertook a diagnostic review in June 2013, and it established that patient pathways were being incorrectly recorded in some cases. Three areas for action were identified. These were systems and processes, capacity and demand, and culture. An action plan was implemented that included updating of data input, recording and reporting, the development of common pathways that were clear to all members of staff, and the rewriting of the trust patient access policy.
- The department had also set up additional clinics and operating lists to meet a target of treating 95% of patients not requiring an admission, and 90% of patients who do require an admission, within 18 weeks of referral from their GP.
- The trust undertook a review of the patients who had missed the 18 week target, and established that treatments for patients requiring urgent care had not been delayed, and those requiring urgent cancer treatment had not been affected either.

Outpatients

- When the shortfall in the 18 week pathway had been identified, the trust wrote to and apologised to patients who had waited longer than 18 weeks. The majority of these patients had then been provided with appointments within four weeks.
- Extra clinics were regularly arranged, in conjunction with the specialist departments, to accommodate more patients. Saturday clinics were also sometimes scheduled, such as for urology.
- We were told of work that was being done in conjunction with local GPs, around the planning of X-ray appointments, which would help waiting times for certain clinics.
- The outpatients manager told us that the departments were being asked to do a 'demand and capacity' exercise. This required them to provide information to the manager of the outpatients department on the number of clinics they would need in order to meet the 18 week RTT pathway.
- The manager said that work was being done to investigate the possibility of some clinics moving to Central Middlesex Hospital and also out into community locations.
- The latest overall trust figures for the 18 week RTT pathway were not available at the time of our inspection. However, staff we spoke with believed that for the majority of people this was being met, although there were still long waiting times for certain clinics.

Access and flow

- There was a patient access centre, where the staff who were responsible for booking and scheduling appointments, and responding to requests for changed appointment times, were located.
- There was a degree of flexibility when patients booked appointments, although this depended on the clinic concerned.
- Clinics could be overbooked and have waiting times of up to two hours. Senior staff told us that this happened regularly for certain clinics, such as orthopaedics.
- The overall percentage of patients who 'did not attend' (DNA) outpatient clinics was between 15% and 16%, which was higher than the national average of 8.5%. Following two missed appointments a decision would be made by the consultant as to whether to refer the patient back to their GP. Staff we spoke with who were running the clinics told us that they were unsure of the causes of the high DNA rates, and were also unaware of what action was being taken to address the issue.
- A trial had been run using texting to remind patients of their appointments, but the trust had decided not to implement this as a permanent service.

Meeting people's individual needs

- Access to the main outpatient department was close to the main entrance to the hospital. The area was open and accessible to patients with mobility needs. Directions were clearly signposted.
- Written information was only provided in English, but could be requested in other languages.
- There were systems in place for staff to use an interpreting service. It could be arranged for an interpreter to be present, or accessed via a phone link. We observed staff in the patient access service organising these arrangements at the time of appointments being scheduled.
- Staff explained how they would liaise with carers or relatives to ensure that people with complex needs, such as learning disabilities or dementia, had the appropriate support when they attended clinics. We observed how one older patient, who was being supported by a carer, was prioritised for treatment in the orthopaedic plaster room. This helped ensure that their distress was minimised.

Learning from complaints and concerns

- Data from the trust showed that there had been no formal complaints made about the outpatients department in the previous 12 months.
- Information about making complaints was displayed in the outpatients area. Senior staff we spoke with were aware of the trust's complaints policy, and the procedure to be followed. Information was also displayed about the Patients Advice and Liaison Service (PALS).
- We observed a healthcare assistant dealing with an informal concern from a patient about an appointment issue. The staff member apologised for any misunderstanding, and asked the patient if they were satisfied with the information they had provided, which they said they were.

Outpatients

- The general manager of the outpatients department told us they would always try and resolve complaints or concerns informally in the first instance, before referring people to the Patients Advice and Liaison Service.
- Patients we spoke with told us they would be prepared to make a complaint if they felt there was a need.

Are outpatients services well-led?

Good

There was a strong caring ethos within the outpatients department, and staff were patient-focused. Staff were clear about the management structure and the lines of accountability. Managers and senior staff were approachable, and staff felt that they listened to their concerns.

Leadership of service

- Staff we spoke with were positive about the management and leadership provided in the outpatients department. Staff were clear about the lines of responsibility, and who was in charge of the various areas.
- We were told that senior staff were approachable and supportive.
- We saw the minutes from team meetings that showed information and issues within the department were discussed.

Culture within the service

- All the staff we spoke with were patient-focused. Several staff commented that they wanted to ensure that the patients had a positive experience of the department. They said that they treated people how they expected themselves, and their family, to be treated.
- Patients we spoke with all described the staff as caring.
- Staff told us that they felt able to comment about their role and the department, and make suggestions during team meetings. They also said that they believed they worked well together as a team in order to co-ordinate patient care.

Public and staff engagement

- Staff were aware of the distribution of trust information via a briefing called 'Team Talk' on the intranet, and also the hospital magazine, which was produced quarterly.
- Several staff had also attended the staff open forums, which had been held in the hospital with members of the trust board. These meetings were held, on average, every three months.

Outstanding practice and areas for improvement

Outstanding practice

- The stroke unit was providing a 'gold standard service' with seven day working. It had been the recipient of the prize for the 2013 Clinical Leadership Team at the British Medical Journal awards.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that there are appropriate numbers of staff to meet the needs of patients in the A&E department, surgical areas and critical care.
- Ensure that there are systems in place to assess and monitor the quality of the service provided in A&E, critical care, surgery and maternity, to ensure that services are safe and benchmarked against national standards.
- Ensure that the environment is safe and suitable in paediatric services.
- Ensure that equipment is available, safe and suitable within paediatric services.

Action the hospital SHOULD take to improve

- Review the coping strategies within A&E during periods of excessive demand for services.
- Empower senior staff to make changes, to ensure that patients are safe in A&E and maternity.
- Ensure that planned changes are undertaken in a timely manner in surgery and in maternity.
- Review discharge arrangements in A&E and critical care to avoid re-admission to these areas.
- Encourage a proactive midwifery department.
- Encourage increased multidisciplinary working in areas such as maternity.
- Review the confidentiality of medical records within the outpatients department.
- Review the effectiveness of clinics to prevent overbooking, late running and cancellations.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who use services and others were not protected against the risks associated with ineffective decision-making in order to protect their health, welfare or safety. In that: Very little information was systematically collected on the safety and quality of care and treatment provided within critical care. Regulation 10 (1) (a) (b) (c)(i) (e) There was a lack of up-to-date protocols and guidelines for staff to work from within surgery. Regulation 10 (1)(b) (2) (b)(iv) The maternity service did not respond to complaints in a timely manner, nor did it actively seek women's feedback on the maternity pathway. Regulation 10 (1) (a) (b) (2) (b)(i) The lack of escalation processes in maternity. Regulation 10 (1)(b)

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Women who use maternity services at Northwick Park Hospital were not protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of – Having their individual needs met as comfort checks on the postnatal ward were not regular. Regulation 9(1)(b)(i)

This section is primarily information for the provider

Compliance actions

Having their safety and welfare ensured because behaviour and attitudes of some midwives towards women fell below expectations. Regulation 9(1)(b)(ii)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises People who use services and others were not protected against the risks associated with the safe and suitability of premises in that: **Jack's Place:** The design of the ward meant that many areas were not observable from the nurses' station, or the reception desk, which posed a safety risk when children were playing in the ward. Regulation 15 (1) (a) The ward appeared clean, but it was cluttered which meant thorough cleaning could not be achieved. Regulation 15 (1)(c)(i) The treatment room and store room doors on the ward were left open, potentially allowing access to children. Regulation 15 (1) (b) On the day of our visit, there were blood samples on a shelf in the open area of Jack's Place awaiting collection, because the pneumatic tube system to take samples to the laboratory was out of order. Regulation 15 (1) (b)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment People who use services and others were not protected against the risks associated with the safety and suitability of equipment in that:

This section is primarily information for the provider

Compliance actions

Jack's place
Not all equipment in the ward was on the trust's asset register, which was why service dates had been overlooked. Regulation 16 (1) (a)

Some electrical equipment did not have PAT testing dates, and trust records showed that on the children's ward 24% of equipment had passed their due date for servicing. Regulation 16(1)(a)

Neonatal unit
We noted that a fridge in the neonatal unit was iced up and there were gaps in the temperature recording. Regulation 16 (1) (a)

Regulated activity	Regulation
	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing People who use services and others were not protected against the risks associated with the safety and suitability of equipment in that: There were inadequate staffing levels to provide safe care to patients within the major's treatment area in the A&E department. Regulation 22 There were low numbers of middle grade doctors in general surgery. Regulation 22 Medical staffing levels were very low in critical care. A large number of positions were filled by locums and clinical fellows. The trainees in the department were very junior and unable to take on many tasks independently. Regulation 22

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North West London Hospitals NHS Trust

St Mark's Hospital

Quality Report

Watford Road
Harrow
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HA1 3UJ
Tel: 020 8864 3232
Website: www.nwlh.nhs.uk

Date of inspection visit: 20-23 May 2014
Date of publication: 20 August 2014

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Requires improvement
Medical care	Requires improvement
Surgery	Requires improvement
Outpatients	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out this comprehensive inspection because North West London Hospitals NHS Trust had been identified as potentially high risk on the Care Quality Commission's (CQC) Intelligent Monitoring system. We undertook an announced inspection at St Mark's Hospital between 20 and 23 May 2014. St Mark's Hospital specialises in gastro-intestinal services and sits within the main trust location at Northwick Park Hospital.

North West London Hospitals NHS Trust is located in the London Boroughs of Brent and Harrow, and cares for more than half a million people living across the two boroughs, as well as patients from all over the country and internationally. The North West London Hospitals NHS Trust manages three main sites registered with the Care Quality Commission: Northwick Park Hospital and St Mark's Hospital in Harrow, and Central Middlesex Hospital in Park Royal. St Mark's Hospital is an internationally-renowned centre for specialist care for bowel diseases. The trust has a sustainable clinical strategy with Ealing Hospital that improves patient pathways, underpinned by combined ICT and estate strategies, and a vision to establish Northwick Park Hospital as the major acute hospital of choice for outer North West London.

Overall, we found the services provided at St Mark's Hospital require improvement to ensure that they are safe, effective and well-led. All services at this hospital were rated as requiring improvement due to lack of staff and coherent processes.

Our key findings were as follows:

- There was inadequate staffing on Frederick Salmon Ward.
- Patients were transferred out of the high dependency unit (HDU) to wards in which staff did not feel confident to manage their conditions.
- There was a lack of junior doctors, and this affected teaching and appraisal opportunities.
- There were delays in emergency surgery taking place.
- Outpatients clinics in the main outpatients department often ran late and appointments were cancelled, sometimes at very short notice.
- Clinics were often overbooked and the delays were not always clearly explained to the patients.
- Staffing was not always sufficiently organised to support and respond to patients waiting for treatment.

We saw areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure that there are adequate numbers of medical and nursing staff on Frederick Salmon Ward to provide care for patients.

In addition the trust should:

- Review the discharge arrangements for patients transferring from HDU facilities, to ensure appropriately trained staff are available to provide safe care.
- Review the availability of elective surgery allocations.
- Review the booking of outpatients appointments to reduce the cancellations and waiting times experienced by patients.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care	Requires improvement 	Medical care on Frederick Salmon Ward requires improvements. While patients on Jonson Ward (Intestinal Failure Unit) received care that was safe, effective and responsive, there were concerns about inadequate staffing, management of deteriorating patients, workload pressures on staff, the teaching and appraisal of junior doctors and a lack of compassion to patient needs on Frederick Salmon Ward. There were enough nursing staff on Jonson Ward (Intestinal Failure Unit) to protect people from avoidable harm, but not on Frederick Salmon Ward. Pain management, infection control and medicines management were largely good in both areas. Medical and nursing staff were described by patients as “polite, respectful, friendly and helpful”. Jonson Ward (Intestinal Failure Unit) was well-led and patients said that it had “good management”. Senior nurses told us that they had good support from their line managers. We observed a lack of integration between St Mark’s Hospital and Northwick Park Hospital, despite being part of the same trust and being physically located on the same site. This led one nurse to describe it as being “them and us”.
Surgery	Requires improvement 	Patients on Frederick Salmon Ward (FSW) received care that was compassionate and responsive. While the day-to-day running of the department generally provided effective care, the department requires improvement nonetheless. The low number of middle grade doctors and the low number of general surgical lists meant that there were delays in emergency surgery taking place and very limited elective general surgery took place. While these concerns had been raised and plans to improve the department had been drawn up, these changes had not occurred. It was not clear if there was a specific date for when these planned adjustments would be made.
Outpatients	Requires improvement 	Patients received compassionate care and were treated with dignity and respect by staff. The

Summary of findings

environment was clean, reasonably comfortable and well maintained. Staff were professional and polite, and promoted a caring ethos. Clinicians gave patients sufficient time in consultations, and patients said that they felt involved in their care.
The trust had taken action to improve the time from patient referral to treatment. Plans were in place to respond to the increased demand for the chemotherapy outpatients service.
The clinics in the main outpatients department often ran late and appointments were cancelled, sometimes at very short notice. Clinics were often overbooked and the delays were not always clearly explained to the patients. Staffing was not always sufficiently organised to support and respond to patients waiting for treatment.

Requires improvement

St Mark's Hospital

Detailed findings

Services we looked at
Medical care (including older people's care); Surgery; and Outpatients

Contents

Detailed findings

Background to St Mark's Hospital

St Mark's Hospital is part of North West London Hospitals NHS Trust and is on the same site as Northwick Park Hospital. It has 64 beds. The Hospital is an internationally-renowned centre for specialist care for bowel diseases. This CQC inspection was not part of an application for Foundation Trust status. The trust is currently undergoing a merger with Ealing Hospital NHS Trust, which is scheduled to become effective in October 2014.

St Mark's Hospital was the first centre in London to open for bowel screening, and the programme has now been extended to people up to the age of 75 from an initial age range of 60-69.

The trust was selected for inspection as an example of a 'high risk' trust.

Our inspection team

Our inspection team was led by:

Chair: Alastair Henderson, Chief Executive, Academy of Medical Royal Colleges

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission (CQC)

The team included CQC inspectors and analysts, doctors, nurses, patient 'experts by experience' and senior NHS managers.

How we carried out this inspection

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

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

The inspection team inspected the following core services at this location:

- Medical care (including older people's care)
- Surgery
- Outpatients

Before visiting, we reviewed a range of information we hold about the hospital, and asked other organisations to share what they knew about the hospital. We carried out an announced visit between 20 and 23 May 2014. During the visit we held focus groups with a range of staff in the hospital, including nurses, doctors, physiotherapists, occupational therapists, porters, domestic staff and pharmacists. We also interviewed senior members of staff at the hospital.

We talked with patients and staff on the wards and in the outpatients department at the hospital. We observed how patients were being cared for, and talked with carers and/or family members, and reviewed personal care or treatment records of patients. We held three listening events where patients and members of the public shared their views and experiences of the hospital.

Detailed findings

Facts and data about St Mark's Hospital

St Mark’s Hospital provides care and treatment for acute and long-term gastro-intestinal and colorectal conditions, and is a national and international referral centre. The majority of surgery is elective, but some emergency surgery is also carried out. St Mark’s Hospital has various research interests and an active teaching programme.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement
Outpatients	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients.
2. We have only inspected and rated the medical, surgical and outpatients areas because the other core services are not provided by St Mark's Hospital.

Medical care (including older people's care)

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

Information about the service

St Mark's Hospital is a national and international referral centre for gastro-intestinal and colorectal disorders. Medical care at the hospital is provided on Jonson Ward (Intestinal Failure Unit) and Frederick Salmon Ward.

Nursing activities include, but are not limited to, supporting the nutrition team with clinical monitoring of patients, teaching and supporting patients requiring stoma or fistula, management of central venous catheters, and making appropriate referrals for patients who require support in the community upon their discharge.

Summary of findings

Medical care on Frederick Salmon Ward requires improvements. Whilst patients on Jonson Ward (Intestinal Failure Unit) received care that was safe, effective and responsive, there were concerns about inadequate staffing, management of deteriorating patients, workload pressures on staff, the teaching and appraisal of junior doctors and a lack of compassion to patient needs on Frederick Salmon Ward.

There were enough nursing staff on Jonson Ward (Intestinal Failure Unit) to protect people from avoidable harm, but not on Frederick Salmon Ward. Pain management, infection control and medicines management were largely good in both areas. Medical and nursing staff were described by patients as "polite, respectful, friendly and helpful". Jonson Ward (Intestinal Failure Unit) was well-led and patients said that it had "good management". Senior nurses told us that they had good support from their line managers.

We observed a lack of integration between St Mark's and Northwick Park Hospitals, despite being part of the same trust and being physically located on the same site. This led one nurse to describe it as being "them and us".

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

The medical service at St Mark's Hospital did not sufficiently protect patients from avoidable harm. Whilst care delivered on Jonson Ward- Intestinal Failure Unit (IFU) was safe, the care delivered on Frederick Salmon Ward (FSW) was not. On the IFU there was adequate staffing, good infection control measures and sufficient equipment to deliver care safely. However on FSW, there were inadequate nursing staff and medical cover, resulting in staff being overworked.

There was also an ineffective process for managing deteriorating patients on FSW. This resulted in difficulty in transferring patients from FSW to the high dependency unit (HDU), and patients being inappropriately transferred to FSW from HDU.

Incidents

- There were no 'never events' reported to the Strategic Executive Information System (STEIS) between December 2012 to January 2014 that were related to medical care at St Mark's Hospital. ('Never events' are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.)
- Nursing staff used an electronic incident reporting system to report serious incidents, and were able to describe the process.
- Minutes from the intestinal failure forum in April 2014 showed that 17 incidents were reported by the IFU at the hospital between February and March 2014. These included laboratory, patient falls and medication incidents.
- All patient falls were recorded on an electronic incident reporting system, in line with the trust's policy.
- Evidence showed that reported incidents were investigated as appropriate, and lessons learnt were documented.
- Analysis of the National Reporting and Learning System (NRLS) notification scores showed that death, severe harm, incidents and harmful events were within statistically-acceptable levels for the trust as a whole.

Safety thermometer

- Staff monitored the safety thermometer scores for the Intestinal Failure Unit (IFU), including pressure ulcers, venous thromboembolisms (VTE), catheters and new urinary tract infections (UTIs), and patient falls.
- For all patients suffering new pressure ulcers, the trust performed better than the England average throughout the entire year.
- A graphic illustration of safety thermometer scores for April 2014 was displayed in the corridor of the IFU, enabling easy access by patients and visitors.

Cleanliness, infection control and hygiene

- We observed the medical wards to be clean and well maintained. Domestic staff were assigned to individual wards to ensure that the areas were kept clean. Patients described domestic staff as "very thorough" and that they were "always cleaning". Cleaning schedules were displayed outside bays and side rooms, and indicated that all areas were cleaned three times daily.
- The patient-led assessment of the care environment (PLACE) in 2013 scored St Mark's Hospital at 98.8% for cleanliness.
- There were good infection control measures, and a high standard of aseptic technique was observed when nursing staff disconnected a patient's Hickman line. A Hickman line is a central venous catheter most often used for the administration of chemotherapy or other medicines, as well as for the withdrawal of blood for analysis.
- Infection control standards were displayed in the IFU corridor in accordance with national guidance.
- Patients with infectious illnesses, or whose status was unknown, were barrier-nursed in side rooms in order to reduce the risk of cross-infection.
- Personal, protective equipment (PPE), such as disposable gloves and aprons, were available in sufficient quantities.
- Staff washed their hands before and after attending to patients, and hand sanitizers were available and easily accessible to all staff.
- The trust's infection rates for C. difficult and MRSA lie within a statistically-acceptable range, taking into account the trust's size and the national level of infections.

Environment and equipment

- There was adequate space between beds on the IFU for the safe delivery of care.

- Fire safety equipment was available and checked annually.
- Resuscitation equipment, including a defibrillator, suction and oxygen, was available and checked daily by nursing staff.
- Staff told us that the wards had the necessary medical equipment, in good working order, to deliver care safely.

Medicines

- We observed nurses on the Intestinal Failure Unit (IFU) checking, administering and signing for controlled drugs, in accordance with legislation.
- Controlled drugs and other medicines on the IFU were stored safely, with access restricted to authorised persons.
- Medication errors per 1,000 were within statistically-acceptable limits.
- Drug fridges were available, and their temperature checked and recorded daily by staff, to ensure that the relevant medicines were appropriately stored.

Records

- Review of several records on the medical wards showed that patients had risk assessments which helped the medical team decide the nature and level of care that was to be delivered.
- 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) forms were completed for appropriate patients, and filed in their medical notes (green form). Two doctors signed the forms in accordance with best practice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients gave their verbal and written consent to have care, tests and treatment carried out by staff.
- Staff told us that if patients lacked the capacity to consent to treatment, medical staff carried out 'mini-mental state' examinations and involved their relatives in order to make best interest decisions as appropriate. There had been no patients on the IFU in the past year that lacked the capacity to consent to treatment.
- Staff told us that no patient has had to be referred for a 'Deprivation of Liberty Safeguards' (DOLS) assessment in the past year on the Intestinal Failure Unit (IFU).

Safeguarding

- Information on safeguarding vulnerable adults was displayed on the IFU, with the details of who to contact in the event of concerns for a person's welfare.
- There was a policy on safeguarding vulnerable adults in place, which staff knew how to access. Training on safeguarding vulnerable adults was available to staff, which covered how to recognise and report safeguarding incidents.
- Records showed that over 88% of staff on the medical areas had attended safeguarding vulnerable adults training, on a three yearly basis, as per trust policy.

Mandatory training

- Mandatory training was available to all staff, including manual handling, health and safety, infection control, medicines management, safeguarding vulnerable adults and basic life support.
- Records also showed that less than 70% of staff were up to date with some mandatory training, including infection control (FSW: 67.9%), health and safety (IFU: 65.7%).

Management of deteriorating patients

- The national early warning score (NEWS) was used by nursing staff to monitor patients' condition and "to provide good care". We found good utilisation of the NEWS system during our inspection. Nursing staff on the IFU told us that if a patient's NEWS score was more than 5, they would escalate the situation by involving the medical and critical care teams. The patient's family would also be notified.
- Staff on Frederick Salmon Ward (FSW; 44 bed, mixed medical and surgical) told us that often the high dependency unit (HDU, in Northwick Park Hospital, transferred patients to them who were not medically fit to be received, resulting in the patients returning to the HDU after a period of time. Staff explained that this was because of "a culture that the nurses on FSW would be competent to deal with those patients".
- Occasionally and in recent times, staff told us that medical staff would go and assess patients on the HDU to determine whether they were fit to be transferred to FSW. However, we were told that even if a patient was medically assessed to be unfit to be transferred to FSW, sometimes the HDU would transfer the patient regardless.
- Staff on FSW also told us that when their patients were assessed to need to go to the HDU, it was sometimes

"difficult to convince the bed managers in Northwick Park Hospital to accept their transfer". This situation of early discharge and difficult readmission meant that patients who were in need of a higher level of care did not receive a level of care that was commensurate with their needs and is potentially unsafe.

Nursing staffing

- On the Intestinal Failure Unit (IFU), four registered nurses (RNs) were rostered on the day shift to care for 21 patients (1 nurse to 5.25 patients). One to two healthcare assistants (HCAs) were also rostered on the day shifts (depending on whether a patient needed to be cared for on a one-to-one basis). Staff told us that this was sufficient staffing to deliver care safely. At night, three RNs and one HCA were rostered to be on duty (1 nurse to 7 patients). These ratios were within the Royal College of Nursing (RCN) guidelines, based on the acuity and needs of the patients.
- There was a vacancy for one nurse on the IFU, and recruitment was in process to fill this post. Bank nurses were utilised to cover staffing shortfalls.
- On FSW there were severe nursing staff shortages. The ward was one nurse short on the day of our visit, due to sickness. This meant that staff were very busy, and a senior staff told us that this was "common". We were told that four beds were closed because it was unsafe to keep them open with the current staffing levels.
- Staff told us that they had difficulty in recruiting nursing staff because some felt intimidated with the "workload and the mixed medical and surgical needs" of patients on Frederick Salmon Ward (FSW). Currently the ward was attempting to recruit one band 5 and two band 7 nurses.
- Senior staff told us that when they were short staffed they could access staff from the Intestinal Failure Unit who were familiar with the work on FSW. If this was not possible, they tended to use staff from other wards or bank staff. However, they said that these staff tended to need considerable support.

Medical staffing

- Medical staff on FSW told us that medical cover was "very thin on the ground" and often junior doctors had to work "very late", often until 10pm at night, because the ward was "so busy".
- Junior surgical doctors told us that their workload was appropriate for them, but felt considerably concerned about the medical patients and the level of their medical cover.
- There was consultant presence daily on FSW, and staff told us that they were approachable.

Major incident awareness and training

Staff on IFU told us that the trust had business continuity plans, but that winter pressure arrangements were not relevant for this unit, due to its speciality and the type of patients that they admitted.

Are medical care services effective?

Requires improvement

The medical service at St Mark's Hospital does not deliver care to patients that is sufficiently effective. Whilst care delivered on the IFU was effective, the care delivered on FSW was not. On both areas, management of patients' pain, maintenance of their nutritional status, and multidisciplinary working, was generally good. However, on Frederick Salmon Ward, there was no formal teaching and no appraisals for junior doctors. Junior doctors were unable to state what the clinical governance arrangements were for the service. Although nursing staff told us that they had been trained with both medical and surgical skills, so that they were are able to care and treat both sets of patients effectively, this posed its challenges.

Nursing staff were unable to assist with the servicing of meals in FSW as the policy on protected meal times was inconsistently applied.

Evidence-based care and treatment

- Policies and procedures were electronically accessible to staff, which they were aware of and which they reported using.
- Care and treatment were reviewed through audits, and we saw evidence of audits on nutrition and pressure area status of patients.
- Patients were provided with information and support to make decisions and choices about their care, treatment and lifestyle.
- The trust has a clinical audit office, which aimed to ensure that the trust was following best practice and monitoring national audits.

Medical care (including older people's care)

Pain relief

- Arrangements for the management of patients' pain were good.
- There was a specialist pain management team for the hospital, who provided advice and support to staff in managing patients' pain. The team included four specialist nurses.
- We observed nursing staff administering pain relief to patients as prescribed.
- Two patients told us that medicines administered by staff were "effective" and "very good" in relieving their pain.

Nutrition and hydration

- There were protected meal times at lunch and supper, to ensure that patients got the nutrition they needed, with as little disturbance and distraction as possible.
- Hostesses were employed on the wards to prepare and serve meals to patients. We observed nursing staff assisting with serving meals to patients. However, catering staff told us that on some wards, when the staff were too busy to assist with serving, the meals would go cold before patients were able to consume it.

Patient outcomes

- Performance information on areas such as equipment, hand hygiene and infection control was readily available to staff, patients and the public, and displayed in the corridor on the IFU.
- Staff we spoke with were able to understand the performance information they received.
- Performance was monitored on the IFU, so that the required changes to practice could be acted upon in a timely manner.
- Staff on the IFU could articulate the plans in place to improve patient outcomes, including working with third party service providers where appropriate. For example, one staff member told us that as the IFU admitted patients from all over the country, they liaised with providers from the patients' local areas, in order to facilitate their transfer or discharge.
- The hospitals performance on the National Bowel Cancer Audit project showed that the hospital was performing worse than expected on three of the five indicators. These included data completion, ascertainment rate (50% v national rate of 95%) and number of cases having a CT scan (8.8% v National rate of 83%). This shows that whilst patients were being seen by specialist nurses and their cases discussed at the multidisciplinary team meetings not all tests were being carried out and the patients care record was missing important items relating to their care.

Competent staff

- Nursing staff on the wards and in focus groups told us that formal supervision of their practice did not take place, but occurred as and when required.
- Nursing staff also told us that they were appraised on their performance on an annual basis, in line with trust policy.
- We were told that junior medical doctors were not employed as trainees, so there was no formal teaching, no appraisals as of yet, and no knowledge of clinical governance.
- Junior doctors felt that the medical handover between doctors on cross-over shifts was appropriate.
- As the wards had a mixture of medical and surgical patients, staff told us that they had been trained with both medical and surgical skills, so that they were able to care and treat both sets of patients effectively. However, one nurse on FSW told us that the nurses considered the ward to be a surgical ward and that they preferred to treat surgical patients. They felt that the nursing staff were "more competent" to care for surgical patients.

Multidisciplinary working

- Multidisciplinary team (MDT) availability was generally good, and included medical staff, nurses, physiotherapists (PHYs), occupational therapists (OTs), dieticians, and speech and language therapists.
- Staff told us that relationships between doctors and nurses were generally good. However, one nurse told us that they sometimes found locum doctors to be "unhelpful". If this occurred, they told us that meetings were arranged with the relevant staff in order to resolve the problem.
- MDT ward rounds took place, involving doctors, nurses and other MDT staff. PHYs and OTs were not based on the wards, but were easily accessible when required.
- MDT meetings took place on a quarterly basis, and staff said that they were "effective".

Medical care (including older people's care)

Seven-day services

- MDT staff were available seven days a week. PHYs, OTs and other allied healthcare professionals began providing a seven-day service in January 2014. They told us that so far, this relative new arrangement was working well.
- Junior doctors did not often work out of hours, as they were locums and did not follow the normal rota.

Are medical care services caring?

Requires improvement

The medical service at St Mark's Hospital does not deliver care to patients that is sufficiently compassionate. Whilst staff on the Intestinal Failure Unit showed care and compassion to patients and relatives whilst delivering care, staff on Frederick Salmon Ward did not always do so. Call buzzers were not always answered in a timely manner, and on one occasion we observed a staff member ignore a patient's request for assistance.

Compassionate care

- We observed staff on the IFU treating patients with dignity, and responding compassionately to patients pain and discomfort in a timely and appropriate way. However, this was not the case on FSW. Here, we observed that one patient had been ringing the buzzer for several minutes. In the end another patient went to their assistance. The patient who gave the assistance told us that it was "commonplace" that they had to assist other patients because "there was just not enough staff around".
- We observed another patient on FSW explaining to a nurse that a patient next to them had been calling the buzzer for several minutes and really needed assistance, but no one had gone to their aid.
- Also on Frederick Salmon Ward, we observed that when a patient asked a staff member to assist them with moving, the staff replied that they were not allocated to the patient's bay and left. Hence, ignoring the patient's request for assistance.
- One patient on FSW told us that they felt "quite scared" because it was coming up to a bank holiday weekend and they did not know how the ward would cope with even fewer nurses. Another patient said that they did not feel that the nurses were "neglectful"; it's just that they were "so busy".
- Five patients told us that they were satisfied with the care they received on the IFU, with one describing it as "very good". Medical and nursing staff were described by patients as "polite, respectful, friendly and helpful". One patient described nurses as having good "bedside manners", whilst another said that if they were not happy with the care they received they would not have stayed on the ward.
- One patient on the IFU told us that nursing staff showed concern for their welfare, and respected their privacy and dignity by ensuring that the curtains were drawn when providing personal care. We observed this to be the case during our visit.
- The CQC's adult inpatient survey of 2013 showed that out of a total of 60 questions, the trust performed the same as other trusts in 53 questions and worse than other trusts in seven questions. One question where the trust performed poorly was to the question "Did nurses talk in front of you as if you were not there?" However, we did not observe such behaviour on the medical wards we visited.
- St Mark's Hospital had 17 'reviews' on the NHS Choices website. Eight of these reviews were included in the analysis dated March 2013 to March 2014. Nine comments were positive and included: "excellent care", "friendly staff", "lovely team", "nurses put me at ease" and "staff are super". Three comments were negative and included: "never had such poor care", "appalling level of care" and "couldn't wait to get out".
- Fredrick Salmon ward at St Mark's Hospital scored just 53 (national average 73) in the February 2014 inpatient Friends and Family Test.

Patient understanding and involvement

- Patients on the IFU told us that they were involved in their care and given information about their condition. One patient told us that "everything was explained" about their treatment.
- Staff provided verbal and written information that enabled patients to understand their care.
- Patients and relatives were able to contact the service when needed, and speak to someone about their care.
- Patients were allocated a named nurse on each shift.

Medical care (including older people's care)

Emotional support

- Patients were supported to stay connected to their family, friends and community during their hospital stay, so that they did not become isolated during their time in hospital. Visitors were encouraged and supported with visiting hours that suited them.

Are medical care services responsive?

Good

The medical service at St Mark's Hospital provided care that was responsive to patient needs. Same sex accommodation was provided in relevant areas, discharge arrangements were in place, and there was an effective system that enabled patients and relatives to raise concerns and make complaints.

Service planning and delivery to meet the needs of local people

- The trust planned services that met the needs of different groups in respect of their equality characteristics. For example, guidance on the provision of same sex accommodation was complied with.

Access and flow

- Patient access to a hospital bed was not always in a ward that was appropriate for their condition. For example, medical and surgical patients often shared the same wards, resulting in challenging demands for nursing staff in particular, in caring for both sets of patients.
- Bed occupancy on the wards was operating to their maximum capacity during our visit.
- Staff told us that medical staff considered all gastro patients to be "St Mark's patients" and if they came to Northwick Park Hospital they were immediately sent to FSW, regardless of whether this was appropriate for their needs or not.
- Discharge arrangements in place were effective. Staff shared patient information with other agencies, such as social services, GPs and other community services.

Learning from complaints and concerns

- During our previous inspection in February 2014, we found that the St Mark's Hospital was in breach of one of their CQC regulatory requirements in that they did not have an effective system in place for identifying, handling and responding appropriately to complaints and comments made by patients or their relatives. The trust sent us an action plan stating that they would be fully compliant with this regulation by July 2014. We will therefore follow up that the trust has complied with this regulation after that date.
- Nevertheless, we were able to ascertain during this inspection that there was a process in place for the receipt, investigation of, and feedback on, complaints.
- Staff reported that they received complaints as well as positive patient feedback. We spoke with staff about recent complaints, and they were able to describe the actions they had taken to address patients' concerns.
- We found during this inspection that the trust addressed our concerns and now had an effective system in place that enabled patients and relatives to raise concerns and make complaints.

Nutrition and Hydration

- Meals arrived on the wards from the kitchen frozen, and were cooked on the wards by the hostesses. Catering staff told us that this was a better arrangement than the previous system of providing 'cooked-chilled' meals to patients.
- All patients had a choice of meals based on their dietary requirements and preferences. They could choose their meals, from a booklet available on the ward, for up to one week in advance. Staff told us that they were always able to cater for the various nutritional needs of patients.
- Patient told us that they were satisfied with the meals, with one saying that the meals were "very good".
- The patient-led assessment of the care environment (PLACE) scored St Mark's Hospital at 76.9% for food.

Are medical care services well-led?

Requires improvement

The leadership and management of the medical service at St Mark's Hospital required improvement due to the lack of integrated working with staff at Northwick Park Hospital which affected the safety of the patients in St Marks Hospital. Staff commented on the "then and us" attitude of a number of staff. Staffing and clinical pressures on FSW revealed a sometimes "frustrated" workforce. Strategic

objectives were regularly reviewed by the board, senior nurses were supported by their line managers, and there were management systems in place which enabled learning and improved performance.

Vision and strategy for this service

- Strategic objectives were regularly reviewed by the board to ensure that they remained achievable and relevant.

Governance, risk management and quality measurement

- The hospital participated in the clinical audits for which it was eligible
- The trust's performance was found to be tending towards 'better than expected' for one of the Audit Commission's Payments by Results Data indicators. Payment by Results aims to support NHS modernisation by paying hospitals for the work they do, rewarding efficiency and quality.

Leadership of service

- Nursing staff on the IFU told us that they felt that the unit was well-led, and patients said that it had "good management".
- Senior nurses told us that they had good support from their line managers.
- Staffing and clinical pressures on FSW had impacted on the staff we spoke with, and discussions revealed a sometimes "frustrated" workforce.

Culture within the service

- The trust's overall staff sickness absence rate was below both the England and London strategic health authority (SHA) averages, between April 2012 and March 2013.
- There was a supernumerary nurse in charge (NIC) during the day, for the medical wards. They enhanced the management of these areas.
- We observed a lack of integration between St Mark's and Northwick Park Hospitals, despite being part of the same trust and being physically located on the same site. This led one nurse to describe it as being "them and us". The trust may find it useful to make note of this.
- The trust was rated as better than expected or tending towards better than expected for 10 of the 28 NHS 2013 Staff Survey key findings. Areas where the staff felt the trust performs well include good communication with senior managers, ability to contribute towards improvement at work, and motivation at work.

Public and staff engagement

- We did not see the results of the Friends and Family Test for the medical wards displayed so that they might be easily accessible to patients and visitors.

Innovation, improvement and sustainability

- There were management systems in place which enabled learning and improved performance. Management systems were reviewed and improved.

Surgery

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

Information about the service

Surgical care at St Mark's Hospital is primarily delivered on Frederick Salmon Ward (FSW). This is a 44 bed specialist colorectal/gastro-intestinal ward, where general surgical and medical patients are also admitted. The hospital shares the same governance and senior management as Northwick Park Hospital.

Summary of findings

Patients on Frederick Salmon Ward (FSW) received care that was compassionate and responsive. Whilst the day-to-day running of the department generally provided effective care, the department requires improvement nonetheless.

The low number of middle grade doctors and the low number of general surgical lists meant that there were delays in emergency surgery taking place and very limited elective general surgery took place. Whilst these concerns had been raised and plans to improve the department had been drawn up, these changes had not occurred. It was not clear if there was a specific date for when these planned adjustments would be made.

Surgery

Are surgery services safe?

Requires improvement

The surgical services require improvement to ensure that patients are treated safely. The lack of medical staff, compliance with mandatory training and the problems with transferring patients who were deteriorating require improvement.

The surgical service learnt from incidents and accidents. There were appropriate ongoing checks on the safety of the service. The policies and procedures of the department were suitable for keeping patients safe.

Incidents

- Between December 2012 and January 2014 four 'never events' took place at the trust. ('Never events' are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.) This was considered to be within the acceptable range. All four of these related to surgical services.
- Staff were able to describe changes that had been made to the way they worked as a result of the review of incidents. We saw records of multidisciplinary committee meetings, where incidents were discussed, including causes and how they would be prevented in the future.
- In addition, the department reported 35 incidents to the National Reporting and Learning System (NRLS). Of these, 24 were classified as 'moderate', three as 'abuse', four as 'severe' and four were deaths.
- Staff were aware of how to escalate incidents within the ward, using an electronic incident reporting system.

Safety thermometer

- The department used a safety thermometer to monitor the safety of the services it was providing. The performance of the department between April 2013 and March 2014 was rated positively at 98.35% harm-free. Results were collected for each ward, so isolated episodes of poor performance could be highlighted.

Cleanliness, infection control and hygiene

- The department undertook regular audits of the standards of infection control. This included aspects of care such as MRSA screening and hand hygiene. In general, the department was compliant with these standards, and the results were presented in a manner that would enable staff to address isolated issues that arose.
- All areas of FSW were clean and tidy. Hand-washing facilities, sinks and personal protective equipment were available throughout.

Environment and equipment

- Appropriate emergency drugs and equipment were available throughout the department. Regular checks were made on these by staff, to ensure that they were in date and in good working order.

Medicines

- All medicines were stored in a secure fashion that made them accessible only to staff. Records were kept of what medicines had been administered.

Records

- We reviewed numerous patient records. All of the records we reviewed showed that basic information and risks assessments were appropriately completed. Patient observations were up to date. Details of daily MDT notes were included, as was discharge data. A recent audit of records showed that this consistent level of completion had been sustained over time.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received mandatory training in Consent, the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.
- There were specific forms to be completed, when a person was unable to consent to surgery, which indicated the reasons for an inability to give consent.
- Departmental staff reported that if they had concerns about someone's capacity to make decisions, they would involve other professionals and the patient's family, as appropriate. Medical staff would undertake any mental capacity assessments.
- In the records we reviewed, patients' consent to surgery was appropriately completed.

Safeguarding

- There was a safeguarding policy and procedure in place.
- Staff received mandatory training in safeguarding vulnerable adults, though take-up of this training was variable across the department.

Surgery

- There was an internal trust safeguarding team to whom staff could report concerns.
- Staff were able to describe the signs of abuse and the actions they would take if they had any concerns about a patient's welfare.

Mandatory training

- The trust kept a record of mandatory training completed by staff within St Marks Hospital. The information provided showed very variable rates of completion of this training across the department. Staff told us it was difficult to attend training due to the workload pressures they experienced.
- Records showed that staff attendance at mandatory training varied depending on the ward/department and the type of training. For example, only 56.6% of staff on FSW had undertaken mandatory training in the past year.

Management of deteriorating patients

- Staff also reported that, on occasions, due to pressure on critical care beds, they had been asked to accept patient transfers before the patient was well enough, which resulted in them subsequently being readmitted to the critical care unit at Northwick Park Hospital.
- The World Health Organization Surgical Safety Checklist was used by the department to ensure that people were safe prior, during and after surgery. Recent audits of the completion of this checklist did not highlight any risks within the department.
- The department used an early warning score system to monitor the ongoing condition of patients. However, staff on FSW had difficulty in transferring patients who were deteriorating to the high dependency service at Northwick Park Hospital.

Nursing staffing

- General surgical and medical patients were admitted to Frederick Salmon Ward. Staff reported that many of the nurses on the wards had surgical training or experience. They told us that they tried to only admit patients when nursing staff had the skills to be able to care for patients following general surgery. However, they noted that at times, due to a lack of availability of beds throughout the wider hospital, patients had to be admitted to FSW, despite the nursing skill mix not being ideal for treating patients following general surgery. Staff did report however, that they had some scope to move staff with particular skills between wards, and they got extra support from specialist staff if they needed it. Senior staff described this as an ongoing challenge.
- Senior staff reported that they used a workforce planning tool, as well as a recently commissioned report by an external company, to decide on the nursing levels and skills mix of nursing staff that they needed on each ward. However, it was noted that at times, nursing staff numbers were low. At one time for 24 patients there had been only five qualified staff, including some still undergoing induction, with no co-ordinator and only two healthcare assistants (HCA). This placed considerable pressure on staff and risked compromising the safety of patients.

Medical staffing

- Surgical medical cover was provided seven days a week on Frederick Salmon Ward.
- Staff reported that there was a lack of junior medical staff since a reduction in the number of trainees following a visit by the Deanery and General Medical Council in 2013. Whilst attempts had been made to mitigate this through the use of nurse practitioners, a second Registered Medical Officer on duty, and recruitment of other staff, this was not sufficient to fill the gaps. It was reported that this put great pressure on junior doctors, and could cause delays in discharge, as medical staff were not available to sign for medicines that patients needed to take home with them.
- Staff reported that whilst they had five emergency surgeons, due to the low number of general surgery lists, there was not enough work for them.

Major incident awareness and training

- There was a major incident policy and procedure in place.
- Staff had training in what to do in the event a major incident and had undertaken simulated exercises.

Are surgery services effective?

Requires improvement

There were trust policies and procedures that were followed by staff to ensure that patients received effective

treatment. Nursing staff received appropriate training and support, and multidisciplinary working was good. However, there was a lack of up-to-date protocols and guidelines for staff to work from.

Evidence-based care and treatment

- Specialist nurses (such as Tissue Viability Nurses) provided specific guidance to staff on any development in their fields. Clinical developments were discussed at handovers.
- Standard risk assessments were used to evaluate patients, and ensure that they were safe whilst within the department. These included Waterlow assessments to check for risk of pressure ulcers, and the MUST nutritional screening tool. There were also specific assessments undertaken to ensure that people were fit and well enough to undergo surgery, which followed national guidelines.
- We looked at a wide number of clinical protocols within the department that related specifically to the care and treatment of patients, such as emergency transfer protocols, analgesia guidelines and fluid management. All of these were out of date, and in the case of the post-operative fluid management guidance, contravened more recent guidance. We were concerned that new students and nurses were referred to these guidance documents to answer any questions they may have.
- Staff undertook audits and checks on medical early warning score charts and malnutrition universal screening tool (MUST) charts, to ensure that they had been completed appropriately. It was noted that St Mark's Hospital's main surgical ward (FSW) scored lower than the wards at Northwick Park Hospital.

Pain relief

- The trust had a specific pain team that worked across the hospital.
- There were specific policies on pain relief within the trust. Staff reported that post-operative pain was discussed with patients at the pre-operative stage.
- Prescribing nurses had specific assessment tools and guidance that they could use to provide pain relief to patients in the absence of medical staff.

Nutrition and hydration

- Patient records we reviewed showed that nutritional assessments and fluid charts had been correctly completed.

Patient outcomes

- The hospitals performance on the National Bowel Cancer Audit project showed that the hospital was performing worse than expected on three of the five indicators. These included data completion, ascertainment rate (50% v national rate of 95%) and number of cases having a CT scan (8.8% v National rate of 83%). This shows that whilst patients were being seen by specialist nurses and their cases discussed at the multidisciplinary team meetings not all tests were being carried out and the patients care record was missing important items relating to their care.

Competent staff

- The trust was currently actively recruiting nursing staff from overseas to make up for a shortfall in UK applicants. Once recruited, they were given more time than UK applicants to adjust to the NHS, and there was a specific induction course for them to complete.
- Nursing staff had access to mentorship programmes. They had annual appraisals, with six monthly reviews. They had supervision, where senior staff assessed their clinical work and provided feedback to them.

Facilities (Only use this subheading if the facilities effects the rating)

- St Marks Hospital utilised the theatre suite in the Northwick Park Hospital site. Of the 13 theatres that were available there were four that were not in use.
- It was also noted that there was limited space within the theatre recovery area. Staff reported that some procedures had to be put 'on hold' until a space was likely to become available in recovery.

Multidisciplinary working

- Nursing staff said that when they requested, surgical staff attended promptly.
- Other healthcare professionals, such as physiotherapists (PHYs) and radiological staff, were available on request from Northwick Park hospital.

Are surgery services caring?

Requires improvement

Some patients we spoke with praised the quality of care delivered by nursing staff. They said that they were well looked after and supported, and we observed this taking

place. However, other patients told us that the medical staff were rushed, and sometimes they did not feel that their care or treatment had been fully explained to them so that they could understand it.

Compassionate care

- The majority of patients were observed to have a named nurse and consultant listed on a poster above their bed. All nursing staff that we observed wore name badges.
- Patients using surgical services told us that they were happy with their treatment and the way they had been looked after. Nurses were described as "caring" and "helpful".
- We observed numerous examples of patients being treated with care and consideration. Their privacy and dignity was respected, with curtains being drawn around their beds when personal care was being delivered.
- The NHS Friends and Family Test results show that Fredrick Salmon Ward was performing significantly below the trusts average score and below the national average.

Patient understanding and involvement

- Some patients said that their time with medical staff had been limited as they were busy. They did not feel that they had received full explanations of their condition/treatment.

Emotional support

- Staff had access to the bereavement services within the trust, as well as different religious persons should relatives/carers require such support

Are surgery services responsive?

Good

Surgical services had plans in place to deal with increases in demand for the service. There were protocols in place to ensure that patients progressed through the department without undue delay, and appropriate discharge arrangements were in place.

Service planning and delivery to meet the needs of local people

- St Marks Hospital took patients from abroad who required gastroenterological surgery. They also received patients from Northwick Park Hospital who required surgical intervention in this speciality.
- Staff reported that the introduction of the Surgical Assessment Unit (Fletcher Ward in Northwick Park Hospital) had made a positive difference to waiting times and patient flow through the hospital.

Access and flow

- On some occasions, a lack of beds available on wards meant that patients spent the night in the recovery room, which delayed the morning surgical lists.
- Discharge planning started pre-admission or on admission, and would involve numerous professionals, including occupational therapists and social services where appropriate. Discharge plans were monitored as part of the daily handover.
- There was a specific risk assessment to be completed before patients were discharged. This looked at what the needs of the patient were, the plans needed to be made, and the resources to be put in place before they were discharged.

Meeting people's individual needs

- There was a range of food options to meet people's cultural or religious needs.
- Translation services were available if people needed them, but staff would also utilise their colleagues who could speak different languages.
- The hospital had a dedicated learning disabilities nurse from the trust.
- Staff received training in caring for, and treating people with, dementia.

Learning from complaints and concerns

- There was a process in place for the receipt, investigation of, and feedback on, complaints.
- Staff reported that they received complaints as well as positive patient feedback. We spoke with staff about recent complaints and they were able to describe the actions they had taken to address patients' concerns.

Surgery

Are surgery services well-led?

Requires improvement

The leadership and management of the medical service at St Mark's Hospital required improvement due to the lack of integrated working with staff at Northwick Park Hospital which affected the safety of the patients in St Marks Hospital. Staffing and clinical pressures on FSW revealed a sometimes "frustrated" workforce. Strategic objectives were regularly reviewed by the board, senior nurses were supported by their line managers, and there were management systems in place which enabled learning and improved performance.

Vision and strategy for this service

- Whilst staff had an idea of the performance of the department, where improvements were needed, and the general plans for making them, staff were not clear on how or when these improvements would be made.

Governance, risk management and quality measurement

- The department collected suitable information on both the safety of the service and the quality of outcomes of treatment.
- There were regular meetings of senior staff, both nursing and medical, where performance was discussed and plans made to address any issues.

Leadership of service

- Staff spoke positively about the current senior management of the trust, and said that they retained the confidence of senior medical staff.

Culture within the service

- Staff we spoke with, at all levels, described friendly and supportive relationships within the surgical services team. However, numerous staff remarked about the pressure that they, and their colleagues, were under.

Public and staff engagement

- The department obtained feedback from patients and relatives via the Friends and Family Test (FFT). However, aside from this and the spontaneous feedback provided by patients and their families, the department did not employ a method to obtain systematic in-depth feedback on the quality of the service they were providing. Senior staff reported that they had plans to introduce a more in-depth patient questionnaire in the near future.

Innovation, improvement and sustainability

- Senior staff reported that they had raised numerous concerns with senior management about the risks they saw throughout the department relating to capacity, resources and the pressures currently being experienced. They said that these concerns were often noted and plans were developed to mitigate them, but despite this, little had improved within the department.

Outpatients

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

Information about the service

St. Mark's Hospital specialises entirely in intestinal and colorectal medicine, and is recognised as a centre of excellence by the World Endoscopy Organisation. It runs a surgical and a medical outpatients clinic from one central location. There is also a chemotherapy outpatients clinic located in a different part of the hospital.

During our inspection we visited the main outpatients area, and also the chemotherapy outpatients clinic. We met with 15 staff including receptionists, nursing staff, healthcare assistants, consultants and administration staff. We spoke with five patients and two relatives.

Summary of findings

Patients received compassionate care, and were treated with dignity and respect by staff. The environment was clean, reasonably comfortable and well maintained. Staff were professional and polite, and promoted a caring ethos. Clinicians gave patients sufficient time in consultations, and patients said that they felt involved in their care.

The trust had taken action to improve the time from patient referral to treatment. Plans were in place to respond to the increased demand for the chemotherapy outpatients service.

The clinics in the main outpatients department could often run late and appointments were cancelled, sometimes at very short notice. Clinics could be overbooked and the delays were not always clearly explained to the patients. Staffing was not always sufficiently organised to support and respond to patients waiting for treatment.

Outpatients

Are outpatients services safe?

Good

The patient outpatients areas were clean and well maintained. Infection control procedures were followed, and regular audits were completed. Patient notes for the individual clinics were kept securely. Medication was securely stored, and regularly checked and audited.

Staff had completed their mandatory training as required. Patients we spoke with told us that they thought the outpatients department was a safe place to visit for treatment.

Incidents

- There had been no serious incidents reported in the outpatients department, and there were no recorded 'never events'. However, in the chemotherapy outpatients clinic, staff told us that they thought there was an under-reporting of incidents using the electronic incident reporting system. We were told that the electronic incident reporting system was not a quick system to use, and staff did not have the time to complete it when they were already stretched.
- The matron told us that they always discussed incidents with staff and shared any learning at the time. They kept a full record of incidents, and any learning was discussed at weekly meetings. The matron assured us that incidents relating to patient safety would be reported.

Cleanliness, infection control and hygiene

- Both the main outpatients department, and the chemotherapy outpatients area, appeared clean and well maintained. The toilet facilities were regularly checked and cleaned.
- Daily infection control audits were completed by the nursing staff, as well as monthly audits by the infection control lead for the hospital.
- Staff adhered to the principles of 'bare below the elbow' in the clinical areas.
- Hand hygiene gel dispensers were provided at the various clinics, with reminders about their usage for patients and staff. We observed these being used by patients and staff.
- Staff completed infection control training as part of their core mandatory training.

Environment and equipment

- We saw that equipment used in the clinical areas was correctly serviced and maintained, and that records were kept. Equipment that had been serviced was labelled and dated. Audits were completed on the servicing of equipment.

Medicines

- Medicines were stored correctly in locked cupboards or fridges where required. The cupboards were checked daily by the nursing staff, and inspections were also carried out by the pharmacy department.
- Patients we spoke with told us that they received appropriate information about the medication they were prescribed, and that changes to their medication were explained to them.
- Written information about medication was only available in English. This could mean that for some patients there could be difficulties in understanding the directions for usage.

Records

- Patient records were protected by being stored securely and confidentially. Records were prepared in the administration room, and then transferred to the main clinic reception ready for the appointments.
- Staff told us that if the full set of patient records were not available, they would occasionally prepare temporary records, so that patients could be seen on the day. However, they said that generally the full set of patient records were available for clinics.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients gave their consent to care and treatment appropriately and correctly. Patients we spoke with told us that the clinical staff asked for consent before commencing any examination or procedure.

Safeguarding

- All nursing and healthcare staff we spoke with confirmed that they had completed safeguarding vulnerable adults training, and were aware of the procedure they were to follow should they need to report a concern.
- Information about safeguarding was displayed in the outpatients area.
- Patients we spoke with told us that they thought the outpatients department was a safe place to visit for treatment.

Outpatients

Mandatory training

All staff were required to complete a range of mandatory training, which included fire safety, safeguarding vulnerable adults, moving and handling, and infection control. Staff we spoke with told us that they had completed these training initiatives, and also any required updates. Mandatory training was checked as part of the staff annual appraisal process.

Are outpatients services effective?

Not sufficient evidence to rate

We report on effectiveness for outpatients below. However, we are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients.

Evidence-based care and treatment

- Staff told us that guidelines such as those issued by NICE were followed where appropriate.

Competent staff

- Staff we spoke with told us that they had annual appraisals on their performance completed by their line managers. During staff appraisals, any mandatory training that a staff member needed to complete was highlighted.
- We spoke with two consultants, and they were positive about the support they received from the healthcare and nursing staff in the department.
- Some staff we spoke with did not feel that they had enough support to manage the difficulties in the department, and that staffing shortages added to the problems.

Multidisciplinary working

- In the chemotherapy outpatients department, there were weekly multidisciplinary meetings between nursing staff, consultants and other professionals, such as pharmacy staff, to discuss patient treatment and progress.
- Staff worked closely with the palliative care team in order to care for people who were receiving chemotherapy. Staff also did liaison work with district nursing services, for people receiving care in their own home, or in a hospice or care home. The department worked closely with the Macmillan nursing service.

Are outpatients services caring?

Good

We found that the outpatients department at St Mark's Hospital was focused on patients, and committed to providing a positive experience of treatment. We observed staff interacting with patients in a caring and respectful manner. All patients we spoke with told us that the staff were caring, respectful and polite.

Compassionate care

- All patients we spoke with told us that the staff were caring, respectful and polite.
- We saw a selection of thank you cards which had been sent to the oncology department. These included comments such as "you are wonderful people and together you make a caring, professional and excellent team", and "thank you for being there and keeping up the banter and laughter no matter how bad I was feeling".
- Patients we spoke with were very positive about the care, treatment and advice they received from all the staff. We were told "the doctor was brilliant, everything was explained calmly and they answered all my questions", and also "the knowledge of everyone is excellent, you know you are in the right place".

Patient understanding and involvement

- Patients were able to get information about medical issues and treatments in leaflets available in the reception area. Patients told us that they were involved in their care, and that the staff discussed all relevant information with them.
- Patients we spoke with told us that they were allocated enough time with staff when they attended their appointments. They said that clinicians were informed about their medical histories, and that staff provided them with detailed information about their conditions and treatment.
- Patients were referred to the outpatients department for investigation or surgery. Patients told us that they had sufficient time to discuss their operation and treatment with a consultant. Two patients told us that they had a

meeting with a specialist nurse following their initial meeting with a doctor. One patient said "it (my treatment) was explained very clearly and carefully and I was told what I needed to know".

Emotional support

- Information was provided to patients about support groups that may be of benefit to them; for example, the stoma support group. Details of a patient helpline were also displayed.
- In the oncology outpatients department, volunteers were available to provide emotional support to patients.

Are outpatients services responsive?

Requires improvement

The trust had taken action to improve the time from patient referral to treatment. Plans were in place to respond to the increased demand for the chemotherapy outpatients services. However, the clinics in the main outpatients area often ran late, and patient appointments were cancelled, sometimes at very short notice. Clinics were often overbooked and the delays were not always clearly explained to the patients. Staffing was not always sufficiently organised to support and respond to patients who were waiting for treatment.

Service planning and delivery to meet the needs of local people

- In February 2013, the trust identified a shortfall in the 18 week patient referral to treatment (RTT) pathway. Following an internal review, action was taken by the trust. A support team from NHS England were engaged to review processes and pathways underlying the 18 week RTT.
- The team undertook a diagnostic review in June 2013, and it established that in some cases, patient pathways were being incorrectly recorded. Three areas for action were identified. These were systems and processes, capacity and demand, and culture. An action plan was implemented that included updating of data input, recording and reporting, the developing of common pathways that were clear to all members of staff, and the rewriting of the trust patient access policy.
- The department had also set up additional clinics and operating lists to meet a target of treating 95% of patients not requiring an admission, and 90% of patients who do require an admission, within 18 weeks of referral from their GP.
- The trust undertook a review of the patients who had missed the 18 week target, and established that treatments for patients requiring urgent care had not been delayed, and those requiring urgent cancer treatment had not been affected either.

Access and flow

- Patients and staff told us that clinics in the main outpatients' area often ran late. On the morning we visited there were two clinics running in the main outpatients department, and both were running between 30 minutes to an hour late. Information about the delays was not displayed for patients. One patient we spoke with told us that they were not told how late the clinics were running, and that they always had to ask staff.
- One clinic had been rearranged and brought forward from 11am to 9am, but the patients had not been informed of the change. This meant that there were no patients for the consultant to see when the clinic started. We spoke with two consultants, and both told us that they thought the booking system could be improved. Clinics were often overbooked, with several patients having the same appointment times.
- Staff told us that the department could become very busy, with long queues at the main reception desk, and patients having to wait to speak to receptionists.
- An audit of clinic start times across the whole trust had shown that 98% had started on time or within a 15 minute margin.
- Two patients we spoke with said that they had had appointments cancelled at short notice. Reception and administration staff told us that patients often attended the clinic before being informed that their appointment had been cancelled. Staff told us that they regularly had to deal with patients who were upset or angry at appointments being cancelled, or at clinics running late.
- Two staff said that they were regularly shouted at by patients who were frustrated by waiting times or cancelled appointments. We were told that some mornings could be very "chaotic". One staff member described a recent morning as being "mayhem", because appointments had been cancelled without

some patients being informed, and clinics were running late. One patient explained how they had had to keep returning to the car park to extend their ticket as they did not know how long they would have to wait.
- In the chemotherapy outpatients, it had been identified that demand was outweighing capacity. A service review had been done in conjunction with the Macmillan nursing service, to increase capacity and staffing. Short-term measures had been implemented, including increasing the number of staff. The long-term plan was to move to another part of the hospital which had more space.

Meeting people's individual needs

- Access to the main outpatients department was via a lift. The area was open, and accessible to patients with mobility needs. Directions to the department were clearly signposted.
- Written information was only provided in English, but could be requested in other languages. There were systems in place for staff to use an interpreting service. On the morning we visited, we saw that one patient had had this service arranged for them. This had been at the request of the consultant, who was concerned that the patient should fully understand their treatment.
- In the chemotherapy outpatients, most medicines were prepared on the day, and this had the potential to cause delays for patients' treatment. Staff were looking into providing the pharmacy staff with a list of prescriptions required for the following day. We were told that the e-booking system being used for colon-rectal and lung cancer patients had speeded up the prescribing process. The system was being extended to include prescribing for other types of cancer.
- There were also a wide range of leaflets that were downloadable from the hospital's website.
- Patient closure meetings were not available in the chemotherapy outpatients' clinic, and a patient survey had shown that only 30% of patients were happy with the information they received after treatment. In response to this, the hospital was about to pilot closure meetings for colon-rectal services.

Are outpatients services well-led?

Requires improvement

Staff were clear about the management structure and the lines of accountability. Administration staff felt that at times, there was a lack of support from management, and that their concerns were not always listened to.

Vision and strategy for this service

- There was no evidence of a vision and strategy for the outpatients department.

Leadership of service

- In the chemotherapy outpatients department staff said that there was strong leadership from the matron. Some staff felt supported and able to approach senior staff for advice or guidance.
- In the main outpatients, healthcare assistants and nursing staff said that they were well supported by the matron, and were clear about their areas of responsibility.
- Administration staff told us that they did not always feel listened to, and there was a lack of support at times from managers. They said that this was particularly true when staffing numbers were low.
- We noted that staff worked well together as a team to co-ordinate patient care.

Culture within the service

- Staff we spoke with were patient-focused, and were positive about providing and improving the service.
- Staff told us that they felt able to comment about their role and the department, and make suggestions, but felt that at times these were not always listened to.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure that there are adequate numbers of medical and nursing staff on Frederick Salmon Ward to provide care for patients.

Action the hospital SHOULD take to improve

- Review the discharge arrangements for patients transferring from HDU facilities, to ensure appropriately trained staff are available to provide safe care.
- Review the availability of elective surgery allocations.
- Review the booking of outpatients appointments to reduce the cancellations and waiting times experienced by patients.