Health and Social Care Scrutiny Sub-Committee AGENDA

DATE: **Tuesday 16 October 2018**

TIME: **7.30 pm**

VENUE: **Committee Rooms 1 & 2, Harrow Civic Centre, Station Road, Harrow, HA1 2XY**

MEMBERSHIP **(Quorum 3)**

Chair: **Councillor Mrs Rekha Shah**

Councillors:

Michael Borio	Vina Mithani (VC)
Maxine Henson	Chris Mote

Reserve Members:

1. Honey Jamie	1. Chetna Halai
2. Natasha Proctor	2. Dr Lesline Lewinson
3. James Lee	

Advisers:

Julian Maw	Healthwatch Harrow
Dr N Merali	Harrow Local Medical Committee

Contact: **Daksha Ghelani, Senior Democratic Services Officer**
Tel: 020 8424 1881 E-mail: daksha.ghelani@harrow.gov.uk

Harrow COUNCIL LONDON

Useful Information

Meeting details:

This meeting is open to the press and public.

Directions to the Civic Centre can be found at:
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Agenda publication date: Monday 8 October 2018

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 5 - 14)

That the minutes of the meeting held on 2 July 2018 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 in which they were received. There will be a time limit of 15 minutes for the asking and answering of public questions.

[The deadline for receipt of public questions is 3.00 pm, 11 October 2018. 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. REFERENCE FROM CABINET - RESPONSE TO THE SCRUTINY REVIEW ON DEMENTIA FRIENDLY HOUSING (Pages 15 - 26)

7. DRAFT DEMENTIA STRATEGY 2018 - 2021 (Pages 27 - 56)

Draft Joint Dementia Strategy 2018-2021, Harrow CCG and Harrow Council.

8. CHANGES TO WALK-IN SERVICES AT ALEXANDRA AVENUE HEALTH AND SOCIAL CARE CENTRE (Verbal Report)

9. HARROW SAFEGUARDING ADULTS BOARD (HSAB) ANNUAL REPORT 2017/2018 (Pages 57 - 110)

Report of the Interim Director of Adult Social Services.

10. LONDON NORTH WEST HEALTHCARE NHS TRUST - CQC INSPECTION REPORT (Pages 111 - 226)

Report of the London North West University Healthcare NHS Trust and Care Quality Commission Inspection Report.

11. NORTH WEST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - UPDATE (Verbal Report)

12. DATE OF NEXT MEETING

Monday, 4 February 2019 at 7.30pm (Harrow Civic Centre).

13. ANY OTHER BUSINESS

Which 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.]

HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE

MINUTES

2 JULY 2018

Chair:	*	Councillor Mrs Rekha Shah		
Councillors:	†	Maxine Henson	*	Vina Mithani
	*	James Lee (3)	*	Chris Mote
Advisers:	†	Julian Maw	-	Healthwatch Harrow
	*	Dr N Merali	-	Harrow Local Medical Committee

* Denotes Member present
(3) Denote category of Reserve Members
† Denotes apologies received

1. Attendance by Reserve Members

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

Ordinary Member	Reserve Member
Councillor Michael Borio	Councillor James Lee

2. Declarations of Interest

Agenda Items 9 to 13:

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

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

3. Appointment of Vice-Chair

RESOLVED: To appoint Councillor Vina Mithani as Vice-Chair of the Health and Social Care Scrutiny Sub-Committee for the 2018/2019 Municipal Year.

4. Minutes

RESOLVED: That the minutes of the meeting held on 14 March 2018, 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

RESOLVED: To note that none were received.

7. Appointment of Advisers

RESOLVED: That the following nominees be appointed as Advisers to the Sub-Committee for the 2018/19 Municipal Year:

1. Mr Julian Maw (Healthwatch Harrow)
2. Dr Nizar Merali (Harrow Local Medical Committee)

RESOLVED ITEMS

8. Scrutiny Review of Access to Primary Care in Harrow - follow up on implementation of recommentations

The Sub-Committee considered a report on the implementation of recommendations arising from a review of Access to Primary Care with a particular focus on those recommendations which involved the NHS Harrow CCG. Javina Seghal, Chief Operating Officer of the CCG, addressed each of the relevant recommendations of the scrutiny review as follows:

Recommendation 1: In total, there had been 1,455 visits to the Harrow CCG website and Health Help Now app in May 2018 by 739 users. Of the 739 users, 385 users were new to the app and website. Since its launch in December 2016, the app and website had been used almost 36,000 times by nearly 22,000 users. There had been 2,596 downloads of the Health Help Now app in that period. 70 users had come direct to the Harrow Health Help Now website and 106 had been referred by other websites. Ms Seghal asked councillors to help increase awareness of the website and app in local communities.

Recommendation 2: A data sharing agreement had been put in place in April 2017 for all three walk-in centres.

Recommendation 3: not for the CCG.

Recommendation 4: The reconfiguration of the first floor at Belmont Health Centre remained a priority scheme for the NHS. There had been some delay due to the funding route changing from NHS England to NHS Property Services. However, tenders had now been returned and adjudicated for the approved scheme, lease terms with the practices were being negotiated and, once these were agreed construction contract would be awarded. The work to reconfigure the first floor of the Belmont centre, estimated to take 5 months, would bring all of the void space back into use, creating additional clinical capacity for each of the GP practices and the Walk-in Centre.

Recommendation 5: There were a number of different engagement forums organised by the CCG; these included monthly peer group meetings where GP practices convened on a geographical basis to discuss topics such as patient experience, access and quality of services. There were also regular respective GP, Practice Manager and Practice Nurse forums which reinforced the collaborative environment. These offered an effective medium through which practices were able to share best practice with a particular focus on improving the patient experience.

Recommendation 6: All Harrow GP practice websites were being refreshed, and the new design of websites would not only contain a 'Self-Help' section, but also a signposting service for patients on conditions that they may have or services that they may require. The new websites would link to the Harrow Help Now website and app download pages. In addition, further designs were being explored, to be implemented within the Health Help Now app, to allow patients to self-refer to services. The CCG would centrally manage the information displayed on GP screens in Harrow and regularly populate it with information about services such as GP extended access, as well as local events in the community and information about public health campaigns.
The Health Help Now app had been widely promoted on the CCG's social media channel, website and through local engagement events.

A Member commended the CCG on progress in these areas; in particular, he considered that the work at the Belmont Centre would take the burden off other services.

Another Member referred to some concerns among residents both about the signposting to the Belmont facility and the need for some cosmetic changes to the premises. Ms Seghal agreed to take these up with NHS Property Services and then update the Sub-Committee. Adam Macintosh, Programme Director, Integrated Urgent Care & Transformation at the CCG, added that the centre was well used with the highest proportion of Harrow residents of the three centres in the Borough. He reported that the common IT platform used across these facilities allowed for availability capacity to be checked online; this would assist in directing patients to the quickest option for an appointment.

In response to a Member's query about public transport access to the Alexandra Avenue Centre, Ms Seghal replied that the CCG would fully support the Council's representations to TfL. Another Member suggested Mr Anthony Wood, Chairman of the Harrow Public Transport Users Association, would also be a useful contact.

Dr Merali asked about the cost-benefit assessment of the walk-in centres in terms of the lowering of pressures on Accident and Emergency units and any financial savings. Ms Seghal advised that this was a very complex assessment given the number of variables involved. It was clear that the centres were helping to manage care outside the hospital environment, with an estimated 7% transfer of cases from A&E. Dr Dilip Patel, Clinical Director, Mental Health at the CCG, underlined that the original objective of establishing the centres was about improved patient access rather than financial savings, because waiting lists for GP appointments were getting longer. The data and patient experience was being assessed, and it was hoped that the centres could, in future, see patients by appointment. In effect, they could develop into local "hubs" for primary care in addition to GP practices.

Ash Verma, Chair of Healthwatch Harrow (Enterprise Wellness Ltd.) confirmed that his organisation supported the hub concept and looked forward to research into how it could work to meet patients' needs more effectively.

Dr Merali asked whether the GP practices nearest the walk-in centres were being disadvantaged and also whether the location of those centres were a matter of pragmatic opportunism rather than planning. Ms Seghal agreed that there may have been some element of practicality, for example, by linking to PFI bids. Dr Patel reminded the Sub-Committee of the Darzai review and the introduction of the "polyclinics" concept. This had not been particularly relevant to Harrow Borough which already had the Pinn and Alexandra Avenue centres; also the concept had its limitations in the sense that a very elderly patient should continue to have access to a GP close by rather than being expected to travel further to receive treatment. Adam Macintosh added that the Pinn and Alexandra Avenue centres had developed more as part of an estate-based initiative, but in the case of Belmont, there had been relevant research and examination of the case for its location. He reported that the Alexandra Avenue centre received more than 30,000 visits per year and that there was now an opportunity to direct patients more effectively to appropriate facilities, eg. through triaging patients from A&E into Urgent Treatment Centres and walk-in centres.

Dr Merali pointed to the impact on GP practices of the development of these new options for care. He considered that this was promoting the trend towards mergers of practices such that he envisaged two large groupings providing primary care services in the Borough within a year or two. Dr Patel referred to the fact that up to 70% of GPs were salaried NHS staff rather than practice partners and that there was no equity of resources across practices. He agreed that groupings were emerging, one as a result of formal mergers and the other developing out of collaborative working between the other services. There was already a formal federation of services in the Harrow Health CIC and there were a number of federations across the country delivering primary care services.

Ms Seghal made it clear that the CCG did not propose mergers to GP practices and there were at present no formal proposals to restructure primary care; if any were forthcoming, there would be a number of steps before they could be implemented. However, practices were perfectly entitled to consider and pursue mergers if they wished. While contracts for walk-in centres were being extended, there was no certainty as to how they would develop in future, and she anticipated that it would take a year or so for plans to take shape.

In response to a Member's question about the governance arrangements in the Federation, Ms Seghal explained that the CCG was solely a commissioning body, not a provider; it was therefore not part of the Harrow Health CIC which was owned by all 33 GP practices in the Borough with each having an equal share. She confirmed that it had a board of management. Dr Patel added that Harrow Health CIC had some 7 years experience of delivering services; he referred to the need for the federation to address the issues of patient access and capacity in the discussions on the future configuration of primary care services in the Borough.

The Chair thanked the CCG representatives and Members for their contributions to this item.

RESOLVED: That the report and the contributions from Members and the representatives of the NHS Harrow CCG be noted.

9. Dementia Friendly Housing Scrutiny Review - discussion with Harrow CCG on the Review's findings and recommendations

The Chair invited Councillors Vina Mithani and Chris Mote, who had both served on the scrutiny review panel, to introduce the item.

Councillor Mithani outlined the findings of the review and the recommendations arising, one of which concerned refreshing the joint dementia strategy between the Council and the CCG. She explained the examples of good practice from other boroughs which had been observed by the review panel. Councillor Chris Mote spoke of his personal experiences recently of a family member with dementia receiving treatment at Northwick Park Hospital. There had been gaps in the information provided and a lack of coordination between agencies; he also considered that the whole "journey" of the person with dementia was not addressed well enough and opportunities were thereby missed, for example, by not coordinating hospital discharges and care at home. He had also encountered a reluctance among some medical professionals to share information with family members even in a case where a Power of Attorney was in place.

Councillor Mithani argued for better integration of services across different agencies to meet the needs of patients more effectively and to make better use of resources. She suggested that more could be done to spread awareness in certain communities, including by visits to places of worship and faith groups; these could complement initiatives undertaken by Public Health England. She referred to the plight of very elderly carers who were faced with difficult, highly emotional situations of their loved-ones' dementia. Councillor

Chris Mote added that, with so many different languages spoken in the Borough, more needed to be done to get messages across to all communities.

Javina Seghal, Chief Operating Officer of the NHS Harrow CCG, thanked the councillors for their rich narrative of issues arising from the scrutiny review, including the important reflection of personal experiences. She referred to the positive atmosphere for and attitude to partnership working in the Borough, and to the active engagement of Members and officers of the Council with the CCG to develop better coordination and integration of services. The intention was to report to the Health and Wellbeing Board on plans and specific proposals, and these would include provision for dementia sufferers and their families. The CCG's performance framework included targets on this area of work.

Lennie Dick, Head of Mental Health Services at the CCG, addressed the meeting, having tabled a document summarising key information and issues. He referred to the national target of maintaining a diagnosis of at least two-thirds as part of the Prime Minister's dementia challenge 2020. The rate in Harrow had been doubled in recent years to reach 64% though there had been some modest slippage in the last year; performance was monitored by an inter-agency group of stakeholders. Mr Dick confirmed that the refresh of the dementia strategy would be brought to the Sub-Committee's next meeting. This would address the challenge of improving awareness of and access to services. In the interim, some new resources had been applied to improve the diagnosis rate and a further increase was anticipated before the end of the year. He outlined the principal challenges in the improvement of services and the key risks, along with possible mitigation measures. also listed a range of initiatives which had already been introduced. Mr Dick concluded by assuring the Sub-Committee that the points raised in this meeting would be addressed in the revised strategy.

Javina Seghal added that some 500 additional referrals per year were required to bring the dementia diagnosis rate in the Borough up to the national target.

A Member asked about the 10-week waiting list for memory assessment and queried how this related to performance elsewhere. Mr Dick said he could provide this information separately. He confirmed that the relevant staff team numbers had been increased and home visits prioritised.

In response to the Member's question about visits to assisted housing accommodation, Dr Dilip Patel, Clinical Director, Mental Health at the CCG, advised that funding had been mad available for advanced nurse practitioners to visit vulnerable patients, particularly those who had been discharged from hospital, and their care plan template included dementia checks. GP training also addressed these issues. Dr Patel felt it was important that relevant professionals regarded the challenge of dementia more broadly, as being about the overall well-being and life experience of those with the condition, rather than purely about clinical diagnosis and medical treatment alone. He appreciated the points made about increasing awareness and understanding in certain communities where there was a reluctance to be open about dementia as it was wrongly associated with madness. Dr Patel hoped that

referrals would become easier and quicker following a decision not to require MRI scans at that stage. He referred to positive partnership meetings to improve coordination and some new initiatives such as the dementia café which made services more accessible for many sufferers.

In response to a Member's question about the difficulty in accessing relevant advice and information via the Council website, it was confirmed that this was being addressed.

A Member referred to the fact that there was only one Milmans facility near the Borough border; he had discussed the provision of "Admiral Nurses" with the Council's social care managers in the context of developing a dementia "hub" in the Borough. He also underlined the importance of the housing element of the scrutiny review panel's work.

In response to another Member's question about the NHS health check, it was confirmed that this now included dementia risk assessment for those in the 45-65 age range.

Lennie Dick confirmed that the CCG would take on board all the points raised by councillors, including the accounts of personal experiences of relevant services. The revised strategy for the period to 2021 would be reported to the Sub-Committee at its next meeting.

The Chair thanked the CCG representatives for their contributions to this item.

RESOLVED: That the report and the contributions from Members and the representatives of the NHS Harrow CCG be noted.

10. Home First and Hospital Transfer Red Bag Schemes

On behalf of the CCG, Adam Macintosh outlined the operation of the Hospital Transfer Red Bag scheme. He advised there were currently 13 Harrow care homes which had gone "live" with the scheme and there were plans for a further 3 homes to join the scheme within the next few months. The scheme was working well, though he considered there was room for some improvement, particularly in the consistency of the use of the bags. It was hoped it could be extended to frail elderly people living alone at home. It had been claimed in Sutton that the scheme was reducing hospital stays by up to three days, though the position in Harrow was not clear as yet. However, it was reducing readmission rates and admissions for non-elective treatment. While funding was due to end shortly, the CCG was addressing how to continue the scheme. In response to a Member's question about tackling isolation of elderly people, Mr Macintosh agreed that this was a central issue to health and well-being, and that the scheme was part of a package to reduce this factor. Ms Seghal added that the Council and the CCG was funding and organisation called Lateral to work on community resilience and cohesion in health and social care.

Mr Macintosh explained that Home First was not a separate service per se, but a number of different strands of work which served to create "wraparound" care for patients at home. The initiative was operating well and, as with the Red Bag scheme, it was hoped funding could be continued. It was part of the

frailty pathway which included a short-stay ward at Northwick Park Hospital which targeted returns home within five days. Ms Seghal underlined the importance of the Council's support in commissioning services in an integrated way. The challenge was to see the value of investment in a high level of care when patients first returned home as this was effective in reducing longer-term needs and costs. A Member referred to the Council's Infinity project as a possible means for more flexible purchasing of care in future.

The Chair thanked the CCG representatives for their report.

RESOLVED: That the report be noted.

11. Healthwatch Harrow Annual Report 2017-18

Ash Verma, Chair of Healthwatch Harrow (Enterprise Wellness Ltd.) introduced the report, outlining the key achievements of the organisation. He referred to the significant budget reductions which had meant that an original annual budget of £175,000 had now reduced to £75,000. As a result, the service was now essentially part-time with a heavier reliance of volunteers. He considered that, despite this, the levels of activity remained high even if the organisation was not in a position to pursue some issues in as much detail as they wished. Mr Verma pointed out that the budget reduction for Healthwatch Harrow was disproportionate when compared to other similar organisations. His Board had commissioned a 360 degree review of the service, as a result of which a merger with Harrow Mencap had been proposed. The Board had decided this would make sense given the value of polling resources and volunteers and given that the organisations were already co-located. He underlined that Healthwatch Harrow would still remain a separate legal entity.

Members commended the work of Healthwatch Harrow as set out in the report. In response to a Member's question about alternative funding options, Mr Verma advised that income generation options were being developed, including a link with Brunel University in delivering some of their courses.

Ms Seghal commended the work of Healthwatch Harrow and described the report as robust and rich in its narrative. The CCG very much valued the organisation's support in reflecting the views of patients and public and thereby playing a key part in shaping effective services.

While congratulating Healthwatch Harrow for its detailed and thorough report, a Member suggested that the organisation should examine the issues of access to GP services and the maternity services offered at Northwick Park Hospital, as these featured consistently in matters raised with her by the public. Mr Verma explained that it was only possible for Healthwatch Harrow to focus on two or three priority issues at a time, as it was otherwise impossible to maintain the quality of the work given current resources. Ms Seghal suggested that the Sub-Committee invite the Northwick Park Hospital Trust to attend one of its meetings to discuss maternity services there; the CCG could also attend to contribute to the discussions.

The Chair thanked Mr Verma for his report.

RESOLVED: That the report be noted.

12. Diabetes Care - Report by Healthwatch Harrow

Ash Verma, Chair of Healthwatch Harrow (Enterprise Wellness Ltd.) introduced the report, thanking the CCG for its support for the work involved. He reported that this was an important area of service as indicated in enquiries from the public and Healthwatch Harrow's own investigations. The research had been carried out between November 2017 and May 2018, and had included focus groups and online submissions; inevitably, it represented a snapshot of the position in this period, but was still helpful in identifying key issues and priorities. Diabetes was significant in Harrow, with the third highest diagnosis rate in the country; it was a particular issue among certain BME communities as had been reflected in the excellent turnout at the launch of the study. Mr Verma pointed to the report's recommendations and suggested that a Borough-wide campaign was needed to raise awareness of the condition and its impact, particularly as it was projected to increase over the coming years. He proposed a coordinated effort between local agencies to ensure the best outcome for such a campaign.

A Member suggested that the message about the condition should be put forward robustly, even to the extent of explaining that people could be faced with amputation of legs and loss of sight if they did not take steps to address their diets and lifestyles. Similar challenging messages had worked in the case of addiction to cigarettes, so he did not consider the approach to be inappropriate. He considered that many people realised the risks too late and there would be benefits in an early, robust message. As he had the condition himself, the Member had been interested in becoming a trainer in this area, but the course demanded three consecutive days' attendance which he could not manage.

Mr Verma reported that Healthwatch Harrow had organised a yoga session during which information on diabetes had been communicated. He commended such innovative ways of getting the message across.

Ms Seghal commended the report by Healthwatch Harrow which had been considered at the CCG Board. She underlined the importance of building on its findings and recommendations.

The Chair thanked Mr Verma for his report.

RESOLVED: That the report be noted.

(Note: The meeting, having commenced at 7.30 pm, closed at 9.48 pm).

(Signed) COUNCILLOR REKHA SHAH
Chair

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LONDON BOROUGH OF HARROW

HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE – 16 OCTOBER 2018

REFERENCE FROM CABINET – 12 JULY 2018

29. Response to the Scrutiny Review on Dementia Friendly Housing

Cabinet noted the following amendment to the financial implications set out in the published report:

"There were no financial implications at this stage arising from the review. Any future cost implications would need to be contained within the existing budgetary provision or be assessed as part of the Medium Term Financial Strategy (MTFS) and the annual budget setting process."

Having received representations from the Vice-Chair of the Scrutiny Review Group in accordance with the Cabinet/Scrutiny Protocol, and another Member of the Review Group, it was

RESOLVED: That

(1) the recommendations of the Scrutiny Review on Dementia Friendly Housing be noted;

(2) the revised financial implications, set out in the preamble above, be noted;

(3) the proposed actions in response to the recommendations as set out in this report be agreed.

Reason for Decision: The recommendations and responses were based on the outcome of the Scrutiny Review.

Alternative Options Considered and Rejected: As set out in the report.

Conflict of Interest relating to the matter declared by Cabinet Member/Dispensation Granted: None.

FOR INFORMATION

Background Documents:
Agenda and Minutes of July 2018 Cabinet meeting – Response Report on Dementia Friendly Housing Review

Contact Officer:
Daksha Ghelani, Senior Democratic Services Officer
Tel: 020 8424 1881

REPORT FOR: CABINET

Date of Meeting:	12 July 2018
Subject:	Response to the Scrutiny Review on Dementia Friendly Housing
Key Decision:	No
Responsible Officer:	Nick Powell, Divisional Director of Housing Services, and Visva Sathasivam, Interim Director of Adult Social Care
Portfolio Holder:	Councillor Phillip O'Dell, Portfolio Holder for Housing, and Councillor Simon Brown, Portfolio Holder for Adults and Public Health
Exempt:	No
Decision subject to Call-in:	Yes
Wards affected:	All Wards
Enclosures:	None

Section 1 – Summary and Recommendations

This report provides responses to the recommendations made in the Dementia Friendly Housing Report from the Health and Social Care Scrutiny Sub-Committee.

Recommendations:

Cabinet is requested to:

- Note the recommendations of the Scrutiny Review
- Agree the proposed actions in response to the recommendations as set out in this report.

Reason: (For recommendations)

The recommendations and responses are based on the outcome of the Scrutiny Review.

Section 2 – Report

Introduction:

In September 2017, the Council's Health and Social Care Scrutiny Sub-Committee carried out a review into dementia friendly housing in the Borough.

The review topic was chosen due to projections in the number of older people in Harrow with dementia and existing national and local focus on the issue.

The purpose of this review was to:

- develop a greater understanding of what constitutes 'dementia friendly' housing;
- develop a greater understanding of and clarity around whether current housing provision within the borough meets the needs of residents aged 65 and over diagnosed with dementia, or those that could develop the condition in the future;
- identify measures that the Council could implement to help meet future housing needs. In doing so, identify what overall steps Harrow Council can take towards becoming more dementia friendly.

The aim was to provide strategic support to the Council's Housing and Adult Social Care departments and Harrow CCG, to help plan for the long-term housing and care needs of those with diagnosed with dementia.

This supports the Council's priority to ***Protect the Most Vulnerable and Support Families***.

Options considered

1. Do Nothing – continue providing services for older people as now
2. Develop different options for older people housing including specialist provision for older people with dementia

Current situation

This report provides responses to the recommendations made in the Dementia Friendly Housing Report from Health and Social Care Scrutiny Sub-Committee.

Recommendation	Response
1. Harrow Council undertakes a detailed and comprehensive needs analysis of demand for accommodation and support for older people in the borough and those diagnosed with dementia and other complex conditions.	The new vision for social care has identified the need to 'transform the offer of care' as one of its key work streams to include building extra care accommodation options. There are currently 109 extra care units in the pipeline and population sampling and needs analysis has commenced to plan for future demand for Harrow's citizens with dementia and other complex conditions. We are exploring options to facilitate access to rented Extra Care and/or dementia friendly housing by owner occupiers in Harrow who require this type of provision, such as the potential to extend the Help2Care scheme where the Council could lease their homes for use as temporary accommodation for homeless families.
2. The outcomes of the intermediate care and wellbeing scheme on an existing site in Pinner Road, Headstone South Ward (if successful) be considered as a business case for developing a cost neutral solution for Extra Care housing within regeneration plans for Poets Corner (site of the Current Civic Centre).	A cross directorate officer team has already met to set an agenda for taking forward a new approach that will increase the range of housing options available to older people in Harrow. A number of site options will be reviewed for the provision of new extra care and extra care plus housing with ability to cater for people with dementia, including the potential for development on the Poets Corner site. These opportunities will be considered within the context of best practice and in accordance with the draft London Plan, with reference to some of the examples explored by the Scrutiny Committee. Consideration will also be given to the potential for existing older persons housing schemes to be upgraded to better

	meet the needs of frailer older people. A report will be brought back to Cabinet later this year on the options to be taken forward and the business case and funding arrangements for the recommended options.
3. Harrow Council produces an older people's housing strategy, which is incorporated within the Council's revised Housing Strategy. The strategy should: a) take into account the provisions made for and funding available to develop specialist older people's housing to support older people diagnosed with dementia; b) take into account the policies and targets set within the Mayor's new Housing strategy and draft London Plan, with regard to the provision of specialist housing for older people with dementia; c) be integrated with health and adult social care priorities and provide a holistic approach to meeting the needs of older people with dementia as their condition progresses; d) take into account best practice examples and learning from other boroughs that have put in place strategies for supported accommodation and support for older people with dementia and other complex needs.	Housing Services will be reviewing all of its published Housing Strategies later in 2018/2019. The Housing Strategy includes a section on supported housing and will be expanded to cover the specific housing needs of older people including those with dementia. The Housing Strategy must be in conformity with the London Housing Strategy and will make reference to the draft London Plan although it should be noted the targets are still to be agreed and therefore our Housing Strategy will focus on what we will be able to deliver taking into account sites and funding availability. The Housing Strategy is developed in consultation with key stakeholders and to meet the joint priorities of housing, health and adults social care priorities. There will be opportunities for officers and members to engage with this strategy and policy review process. The revised Housing Strategy will be brought to Cabinet for approval next year. See above section regarding applying best practice examples in taking forward new opportunities for developing extra care housing in Harrow.
4. The borough's joint dementia strategy is refreshed to include: a) progress of outcomes from the previous strategy; b) integrated policies and action plans that meet the health, housing and social care needs of people with dementia in the borough; c) a care dementia care pathway to ensure improved post diagnosis care and support; better awareness and access to information and advice services via the council, the	a) Harrow has one of the highest proportions of older residents aged 65 and over. The Census indicates that 14.1% (33,637) of Harrow's residents are aged 65 and over. The prevalence of dementia in this group is around 2,500 and the rate of dementia diagnosis in Harrow has increased significantly over the last two years. - Discussions are taking place with Harrow CCG with a view to revising the dementia strategy, which will be published at the end of 2018.

CCG and through local voluntary and community sector (VCS); d) details of plans for the development of a dementia information and advice hub for Harrow. (to Harrow Council and Harrow Clinical Commissioning Group)	- We are working in partnership with the Harrow Memory Assessment Service (MAS) to ensure that dementia patients have access to and are referred to appropriate services within the borough. - Processes have been put in place to facilitate regular engagement with older people services within the borough. - A social worker is now co-located in the team. b) As part of our plans to refresh the joint dementia strategy, a multi-agency stakeholder task and finish group will be established to ensure that health, housing and social care strategies and priorities are incorporated. Opportunities will be identified to engage with and consult people living with dementia and their families and carers. c) We have taken on board the findings of the report and feedback from service users. Newly diagnosed patients and their carers now receive a post-diagnostic information pack. d) Plans for the development of the dementia and information hub align with the Adult Social Care Pathway review to optimise the customer journey and to make for a personalised experience. The Hub will blend raising awareness of latest technological advances e.g. enhanced telecare, through to offering information and advice on a digital platform, e.g. Harrow Council's website front end. Online information will be complimented with a physical space to cater for people who do not go online, enabling people with an option to drop in for support that is well linked to key touch points in the dementia pathway. This offers a multi-tier level of support for citizens in Harrow affected by dementia to have access to the necessary information as listed above. The potential for new and emerging assistive technology to significantly improve

	the lives of people living with dementia is recognised and officers intend to engage with these opportunities alongside key partners. Examples include internet-connected sensors and wearables to monitor people with dementia and GPS enabled wearables.
5. Council departments are encouraged to explore opportunities for increased partnership working with: a) Harrow CCG to ensure better integration of health and adult social care services, improved awareness of and signposting to other services in the borough and identify gaps in service provision; b) local VCS sector to raise awareness of dementia diagnosis and support services among BAME communities.	a) Harrow CCG commissions the Memory Assessment Service which provides extensive information to all newly diagnosed patients and carers and the public. Future planned work will see increased information through GPs and the CCG website. The review of the adult social care pathway will realise opportunities to better integrate working. b) The Minority Ethnic Elders Project and the work of commissioned groups like Harrow Association of Somali Voluntary Organisation continue to extend the reach to BAME Communities. A task and finish group has been established in response to the VCSE Review 'Strengthening the VCSE relationship with the council' this is consistent with the Adult Social Care transformation that sees community resilience as its bedrock and using a co-production / co-design process as intent to increase partnership working. Involving stakeholders affected by dementia is key to ensuring that people's awareness of diagnosis and support is heightened among BAME communities.
6. The Chair of the Harrow Health and Social Care Scrutiny Sub-Committee, invites Harrow CCG's Chief Operating Officer to a future meeting of the Health Sub-Committee to respond to the findings of this report.	The Chief Operating Officer of Harrow Clinical Commissioning Group has accepted an invitation to attend the next Health Sub-Committee meeting in July to discuss the findings of the report.
7. Additional action following Cabinet briefing	Consideration will be given as to how all Council activities can become more dementia-friendly in the context of both increased demand for services and increasing budget challenges, including exploring options such as the dementia-friendly communities programme.

Risk Management Implications

There are no risk implications at this stage.

Procurement Implications

There are no procurement implications at this stage.

Legal Implications

There are no legal implications at this stage.

Financial Implications

There are no financial implications at this stage.

Equalities implications / Public Sector Equality Duty

Dementia friendly housing usually relates to older people and the protected characteristics of age and disability. However there are no specific equalities implications arising from the recommendations in this report at this stage and it is considered that generally the impact on protected groups would be positive.

Equalities impact will be considered separately for actions or proposals that develop out of the recommendations in the report.

Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

This report incorporates the administration's priority to

- Making a difference for the vulnerable

And the *Harrow Ambition Plan's strategic themes to* ***Build a Better Harrow*** *and to* ***Protect the Most Vulnerable and Support Families****.*

Section 3 - Statutory Officer Clearances

Name: Donna Edwards and Tasleem Kazmi, Finance Business Partners Date: 2 July 2018	X	on behalf of the Chief Financial Officer
Name: Matthew Adams, Principal Lawyer & Service Manager – Commercial Date: 2 July 2018	X	on behalf of the Monitoring Officer

Section 3 - Procurement Officer Clearance

Name: Nimesh Mehta, Head of Procurement Date: 2 July 2018	X	Head of Procurement

Ward Councillors notified:	**NO, as it impacts on all Wards**.
EqIA carried out:	**NO** *Not required for this report as this report only outlines responses to recommendations.*
EqIA cleared by:	Not Applicable

Section 4 - Contact Details and Background Papers

Contact:

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Background Papers: None

Call-In Waived by the Chair of Overview and Scrutiny Committee	**NO** (Call-in applies)

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Harrow CCG and Harrow Council

Joint Dementia Strategy

2018 – 2021

Draft Version: Final

Contents

EXECUTIVE SUMMARY

Dementia is the term used to describe a progressive illness that usually harbours a number of symptoms including memory loss leading to a decline in a person's functioning. The condition does not only affect the memory but also affects intellect, rationality, social and emotional reactions.

We recognise that living with dementia and supporting a person with dementia can be very challenging and that situations can arise that are difficult for the person with dementia or those supporting them. We believe that working collaboratively we can deliver sustained improvements in dementia services and make Harrow more dementia friendly.

The condition is sometimes associated with stigma and cultural taboo which often leads to social exclusion, discrimination and disempowerment in some cases. The stigma affects a person's ability to seek help which, in turn, affects the process of early diagnosis and assessment as well as referral to services and support.

The Royal College of Psychiatrist describe Alzheimer's disease as the most common cause of dementia which accounts for about 7 in 10 of all dementias. It typically begins with memory problems and slowly gets worse over time. People will often notice that they can't remember things that happened recently, even though they can still remember what happened years ago. They will often find that they have difficulty recalling particular words and naming objects.

Vascular dementia is another form of dementia which is caused by the blood vessels supplying the brain becoming damaged or blocked. This can lead to small strokes, or parts of the brain dying, as they are starved of oxygen and nutrients. This dementia can come on more quickly than Alzheimer's. Someone with vascular dementia is more likely to suffer from conditions which lead to blocked arteries, such as high blood pressure, smoking, diabetes or high cholesterol.

We are working hard to raise community awareness about the effects of the stigma associated with dementia, to address the need to change the way people approach dementia, make recommendations for further action and to empower people living with dementia to achieve their potential.

Harrow CCG, Harrow Local Authority and Public Health Harrow are committed to improving the patient's journeys in terms of living well with dementia. There has been an

increasing focus on the Dementia Diagnosis Rate, to enable easy access to care, support and advice following diagnosis. The intention is to increase the level of diagnosis to ensure appropriate post diagnostic support for patients and carers creating a more Dementia friendly Borough.

The percentage of people diagnosed with Dementia in relation to the prevalence of dementia in Harrow at August 2018 is 64%. Both the prevalence rate and the number of people being diagnosed have risen 14% since 2015.

STATUTORY AND NON-STATUTORY GUIDANCE

On the 20 June 2018 the National Institute for Health and Clinical Excellence published 'Nice Guidelines for Dementia focusing on; assessment, management and support for people living with dementia and their carers.

The guideline complements existing legislation and guidance and aims to describes how services and professionals can provide high-quality care and support.

The Prime Minister's Challenge on Dementia 2020 sets out the UK Government's strategy for transforming dementia care within the UK. The aims of the strategy include:

- improving diagnosis, assessment and care for people living with dementia
- ensuring that all people living with dementia have equal access to diagnosis
- providing all NHS staff with training on dementia appropriate to their role
- ensuring that every person diagnosed with dementia receives meaningful care.

Since the 2006 NICE guideline on dementia was developed, key new legislation has been implemented. The Care Act 2014 created a new legislative framework for adult social care, and also gives carers a legal right to assessment and support.

<u>Relevant legislation and statutory guidance</u>

- NHS England (2015) Accessible Information Standard
- Care Act 2014
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Department of Health (2014) Care Act 2014: Statutory Guidance for Implementation

- Department of Health (2014) Positive and Proactive Care: Reducing the need for restrictive
- Interventions
- Health and Social Care Act 2012
- Equality Act 2010
- Mental Capacity Act 2005
- Human Rights Act 1998

Relevant policies and non-statutory guidance

- Information Commissioner's Office (2017) Guide to the General Data Protection Regulation
- NHS England (2017) Dementia: Good Care Planning
- NHS England (2015) Implementation guide and resource pack for dementia care
- Skills for Health, Health Education England and Skills for Care (2015) Dementia Core Skills Education and Training Framework. This framework was commissioned and funded by the Department of Health and developed in collaboration by Skills for Health and Health Education England in partnership with Skills for Care
- Department of Health (2014) NHS Outcomes Framework 2015 to 2016
- Department of Health (2014) Adult Social Care Outcomes Framework 2015 to 2016

UNDERSTANDING THE CHALLENGE

Dementia is a growing challenge. As the population ages and people live for longer, it has become one of the most important health and care issues facing the world. In England it is estimated that around 650,000 people have dementia. In the whole of the UK, the number of people with dementia is estimated as 850,000.

Dementia mainly affects older people, and after the age of 65, the likelihood of developing dementia roughly doubles every five years.

However, for some dementia can develop earlier, presenting different issues for the person affected their carer and their family. There are around 540,000 carers of people with dementia in England. It is estimated that one in three people will care for a person with dementia in their lifetime. Half of them are employed and it's thought that some 66,000 people have already cut their working hours to care for a family member, whilst 50,000 people have left work altogether.

There is a considerable economic cost associated with the disease estimated at £23 billion a year, which is predicted to triple by 2040. This is more than the cost of cancer, heart disease and stroke.

What is dementia?

Dementia can be described a brain disease which often starts with memory problems, but goes on to affect many other parts of the brain, producing:

- Memory loss
- Feeling anxious
- Language impairment
- Disorientation (not knowing the time or place)
- Change in personality (becoming more irritable, anxious or withdrawn; loss of skills and impaired judgment)
- Self-neglect
- Behaviour which is out of character

Studies have shown that dementia gets worst. It is more common in older people and it may also run in families. A person with dementia may lose empathy, they may see or hear things that other people do not (hallucinations), or they may make false claims or statements.

Contrary to common belief, dementia is not one specific disease but is an umbrella term that describes a wide variety of symptoms that damages the brain cells. Dementia is progressive, meaning that it gradually gets worse. And sadly, there is no cure for most forms of dementia. “People typically think Alzheimer’s is dementia. In fact, it is one of the many forms of dementia.

As dementia affects a person's mental abilities, they may find planning and organizing difficult. Maintaining their independence may also become a problem. A person with dementia will therefore usually need help from friends or relatives, including help with decision making. Patients may have difficulty feeding, dressing and washing themselves and are highly dependent on carers.

Most types of dementia can't be cured, but if detected early there are ways to slow it down and maintain mental function. Everyone's experience of dementia is unique and the progression of the condition varies. Some symptoms are more likely to occur with certain types of dementia.

Why it is important to get a diagnosis

An early diagnosis opens the door to future care and treatment. It helps people to plan ahead while they are still able to make important decisions on their care and support needs and on financial and legal matter. It also helps them and their families to receive practical information, advice and guidance as they face new challenges.

Diagnosis will help them gain access to resources and support, make the most of their abilities and also benefit from drug and non-drug treatments available.

Why people may shy away from diagnosis

Harrow has a diverse population and diagnosing people with dementia is a challenge. Generally the public have concerns over the impact on their daily lives. Particularly in their jobs, social lives, cultural belief and the ability to drive and in many cases the stigma is associated with dementia. For these reason, some families, carers and suffers prefer not to seek a diagnosis when early signs of dementia are present**.**

- 49 % of people are worried that they would be seen as mad after a diagnosis of dementia
- 56% of people put off seeking diagnosis for up to a year of more.
- 62% of people feel that their life is over after diagnosis.
- 58% of people feel that they will struggle to join in conversations or enjoy the things they used to enjoy the things they used to.
- 42% believe that once a person living with dementia stops recognising loved ones, they don't benefit from spending time with them.
- 68% believe that they will be a different person if they were diagnosed of dementia.
- 68% of people feel isolated following a diagnosis of dementia
- 85% of people want to stay at home as long as possible after a diagnosis of dementia.

Source: Alzheimer's Society / Dementia statics.org (2016)

Early and Late onset dementia

Early-onset of dementia is used to describe the situation where dementia is developed before the age of 65. It is estimated that at least 42,000 younger people are living with dementia in the UK **(2014)** Prince M et al, Dementia UK.

Late-onset of dementia refers to patients who develop dementia after the age of 65. Late-onset dementia is far more common than early-onset dementia, because dementia is primarily a disease associated with ageing. However the underlying disease for all age ranges is the same.

Underlying causes of dementia

The most common causes of dementia are age-related neurodegenerative processes. These refer to diseases or injuries which affect the function of the brain. There are a number of such diseases which cause dementia. The most common cause of dementia is Alzheimer's disease, followed by vascular dementia.

It is important to make a distinction between the different underlying causes of dementia because they vary in the range of symptoms suffered and the rate of progression of symptoms. The key features of the most common underlying causes of dementia are summarised as:

Alzheimer's disease:

- The most common cause of dementia.
- Damaged tissue builds up in the brain to form deposits called 'plaques' and 'tangles'. These cause the brain cells around them to die.
- Characterised by a gradual progression of symptoms.
- The first symptoms to appear are usually a loss of memory.
- Learning new information becomes harder
- As symptoms progress, the person will have increasing difficulty carrying out daily functions.

Vascular dementia

- This is when the arteries supplying blood to the brain become blocked
- This leads to small or big strokes
- Parts of the brain die as they are starved of oxygen.
- Unlike Alzheimer's, progression of symptoms may be sudden (after a stroke) or step-wise rather than gradual.

Dementia with Lewy bodies:

- Associated with protein deposits that develop inside nerve cells in the brain and affect the function of the brain
- Type of dementia may have symptoms similar to those of Parkinson's disease, such as tremors and slowness of movement.

- The disease is progressive, although a person's level of function may fluctuate on an hourly basis.

Front temporal dementia

- Is rare, and can be caused by a number of degenerative diseases affecting the brain including Pick's disease.
- In the early stages of disease, memory is often intact, but personality and behaviour change are apparent.
- Incontinence may be a relatively early feature of the disease.
- This often starts in people in their 50s and 60s.

Mild cognitive impairment

- When memory problems are more than you would expect for your age, but not bad enough to be called dementia. About 1 in 3 people with this problem may develop dementia

RISK FACTORS FOR DEMENTIA

Risk factor in this context means anything that can increase a person's risk of developing dementia. Some of these factors can be avoided or managed but some are impossible to control. For example; high blood pressure can cause strokes and strokes can cause vascular dementia, high blood pressure is a risk factor for vascular dementia.

The most important non-modifiable risk factor for dementia is age. A number of modifiable risk factors for dementia exist. These include the risk factors for vascular diseases, such as diabetes, hypertension, smoking and high cholesterol, which all increase the likelihood of both vascular dementia and Alzheimer's disease. Excessive alcohol consumption is also an important modifiable risk factor.

Risk factors for dementia

Risk factor	**Comments**
Non-modifiable risk factors	
Age	Increasing age is the most important risk factor for dementia.
Sex	Alzheimer's disease is slightly more common in women, particularly in those over 80 years of age

Genetic factors	Mutations in 3 individual genes cause familial Alzheimer's disease. Down's syndrome is associated with an increased risk of Alzheimer's (this is rare)
Family history	Family history of a first degree relative with Alzheimer's disease may increase the risk of Alzheimer's, however caution should be used when interpreting this information and association can only determine on an individual basis given the number of other associated variables.
Modifiable risk factors	
Hypertension	Associated with an increased risk of both vascular dementia and Alzheimer's disease.
High cholesterol	Associated with an increased risk of both vascular dementia and Alzheimer's disease.
Diabetes	Associated with an increased risk of both vascular dementia and Alzheimer's disease.
Smoking	Associated with an increased risk of both vascular dementia and Alzheimer's disease
Excessive alcohol consumption.	Excessive alcohol intake is associated with Korsakoff's syndrome, and other of types of dementia.
Educational level	Additional years of education appear to offer some protection against Alzheimer's disease.

Source: Kester and Scheltens. Dementia UK: The Bare Essentials Pract Neurol **(2009)**; **9:**241-251

<u>People with learning disabilities and Dementia</u>

People with learning disabilities, particularly those with Down's syndrome, are at increased risk of developing dementia. Professionals must ensure additional time and adjustments particularly with communication allowing expression on how they feel if their abilities have deteriorated. Communication difficulties will make it harder for others to assess change.

THE NATIONAL CONTEXT

Prevalence of dementia in the UK

It is estimated that about 850,000 people are living with dementia in the UK. It is difficult to know the exact number of people living with dementia due to its gradual nature, the mild early-stage symptom and low diagnosis rate.

About two in 100 people aged between 65 and 69 have dementia, and this figure rises to one in five for those aged between 85 and 89 (*Dementia UK).*

In terms of the rising care needs of people with dementia, it is estimated that in England over the next 30 years it will more than double to 1.4 million. The health social costs are currently at a critical level with all the evidence showing accelerated demand.

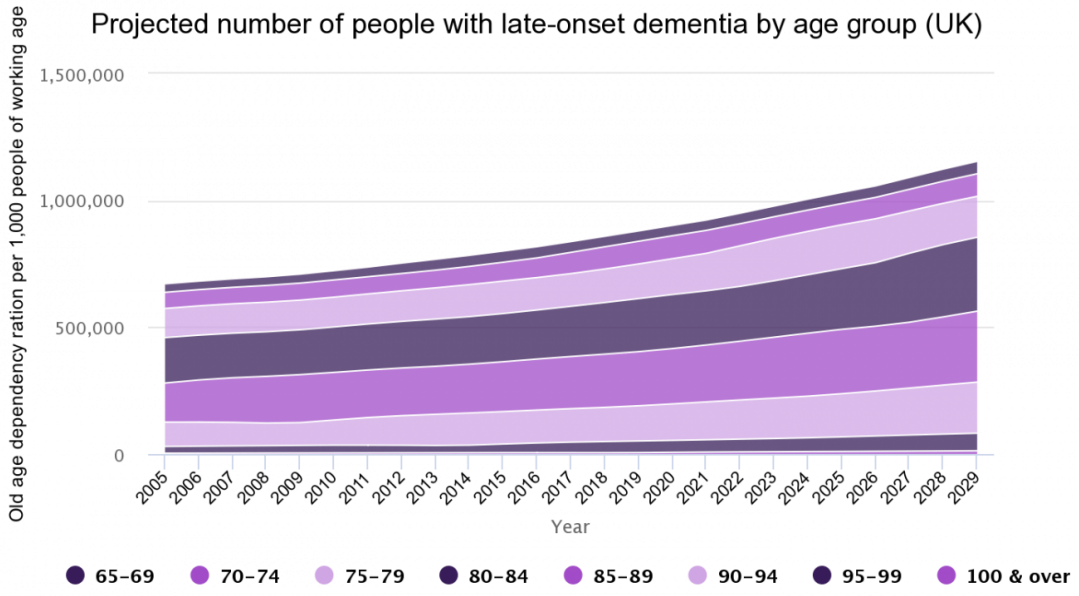
Demographic change will drive significant growth in the number of people with dementia, even though the percentage of older people developing some types of dementia (particularly vascular dementia) may decline as a result of reductions in hypertension and other risk factors (Snell T, Wittenberg R, Fernandez JL, Malley J, Comas-Herrera A, King D, **2011**).

Research suggests that approximately one in four patients in acute hospitals have dementia and that these needs are not currently well responded to Lakey (**2009**).

Staff in acute settings and care homes may need extra training in caring for people with dementia and delirium. The cost of dementia will rise by 61 per cent to £24 billion by 2026 (at 2007 prices), with most of this cost being met by social care and by individuals and families rather than the NHS (McCrone P, Dhanasiri S, Patel A, Knapp M, Lawton-Smith S, **2008**).

Harrow has to look at ways of developing effective preventive/management interventions that could offset some of these significant costs in view of its local fiscal challenges.

Projected UK dementia trends



Source: Knapp M, Prince M **(2007)**. Report. Dementia UK*London School of Economics, King's College London and The Alzheimer's Society*

The National Dementia Strategy

Dementia is currently estimated to cost £26 billion to the society more than the cost of cancer, heart disease or stroke and this is expected to triple by 2040. Dementia has become a key priority for both NHS England and the Government (Lewis et al, **2014**).

NHS England plan to achieve the following by 2020

- Equal access to diagnosis for everyone
- GPs playing a lead role in ensuring coordination and continuity of care for people with dementia
- Every person diagnosed with dementia having meaningful care following their diagnosis
- All NHS staff having received training on dementia appropriate to their role.

The Prime Minister's challenge on dementia 2020

The goal of the new challenge is to consolidate and build on the progress made since the first challenge issued by the Prime Minister in 2012. The challenge aims to make

England the best place to live well with dementia for patients and families by 2020, and the best place in the world to undertake research into dementia and other neurodegenerative diseases.

The implementation plan focuses on four core themes:

- Risk reduction
- Health and care
- Awareness and social action
- Research.

The challenge has identified 18 fundamental commitments. These commitments are specifically about improving public awareness and understanding the factors that increase the risk of developing dementia and how individuals can reduce their risk through healthy lifestyles. This plan will involve a healthy aging campaign and access to tools such as personalised risk assessment calculator as part of the NHS Health Check.

There is emphasis on risk reduction. This will be delivered as a pilot scheme in partnership with voluntary sector organisations using the existing NHS Check to provide training around the risks of developing dementia and the steps they could take to reduce those risks.

Industry sectors are encourage to develop Dementia Friendly Charters and work with business leaders to make individual commitments and also become dementia friendly.

Harrow Local Authority undertook a Dementia Friendly Housing review to:

- develop a greater understanding of what constitutes 'dementia friendly' housing;
- develop a greater understanding of and clarity around whether current housing provision within the borough meets the needs of residents aged 65 and over, diagnosed with dementia, or those that could develop the condition in the future;
- identify measures that the Council could implement to help meet future housing needs and in doing so, identify what overall steps Harrow Council can take towards becoming more dementia-friendly.

Dementia Research will become a career opportunity of choice with the UK being the best place for Dementia Research. An international dementia institute is to be established in England and increased investment in dementia research will be encouraged. https://www.gov.uk/government/publications/prime-ministers-challenge-on-dementia-2020/prime-ministers-challenge-on-dementia-2020

LOCAL CONTEXT

Statutory Dementia Service in Harrow

Harrow council has a statutory duty to carry out a community care assessment, which will assess the person's needs and identify which services could be arranged to help meet these needs.

The Council can also provide a carer's needs assessment which can help carers to access services to support them with their caring role.

The council has equipped various voluntary sector workers and volunteers in terms of supporting people with dementia through training programmes. These courses are person centred and also a practical way of sharing knowledge and raising awareness of dementia amongst carers and within the voluntary sector.

Harrow Memory Services

The Memory Assessment Service (MAS) as part of Central and North West London NHS Foundation Trust (CNWL) provides a comprehensive assessment of an individual's memory, ensuring that if dementia is an issue a diagnosis is given as soon as possible. Once a service user has been diagnosed, the services can help to support the individual in coming to terms with their diagnosis and sign-post to agencies for post diagnostic support. They provide useful strategies and treatments to help people minimise their memory difficulties. Their primary objective is to help people live independently and safely.

The Harrow Older People Community Mental Health Team

The team has three key functions:

- To give advice on the management of mental health problems by other professionals – in particular,
- providing advice to primary care, such as GP surgeries, and making sure appropriate referrals are made.
- Providing treatment and care for those with short-term mental health issues who can benefit from specialist
- Interventions.
- Providing treatment and care for those with more complex needs.

Harrow's elderly population

There are 31,900 of older residents aged 65 and over. Harrow has one of the highest proportions of older residents aged 65 and over compared to other London boroughs at 15.2%. Old age is the most important risk factor for dementia and Harrow has the highest percentage of elderly residents of the 8 boroughs in the North West London sector. This is below the national average of 16.3%. Harrow is ranked 7th in London for the proportion of residents aged 65 and over. (ONS LSOA Mid-Year Estimates **2016**)

Percentage of population over the age of 65 – North West London Boroughs.

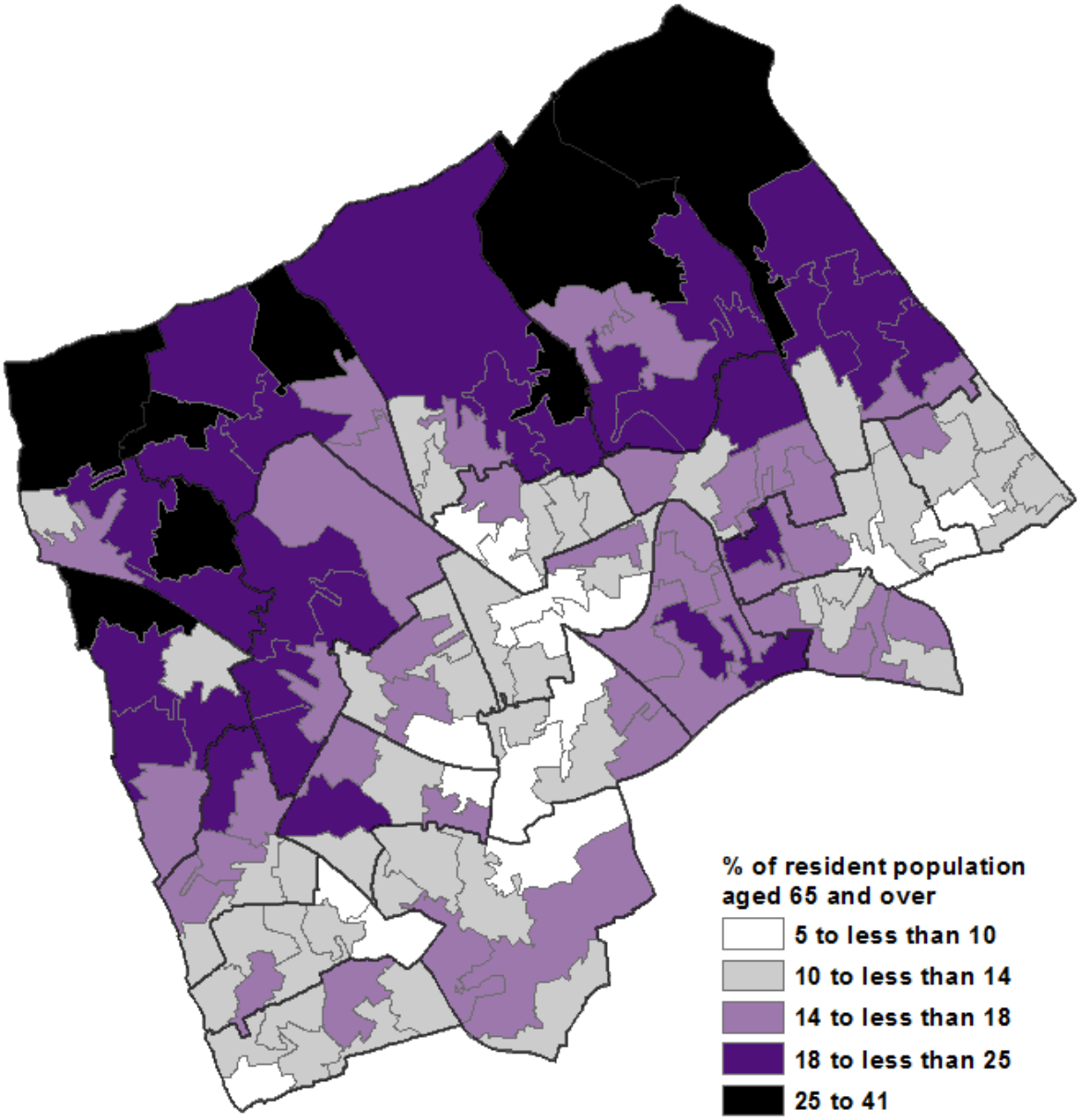
London Borough	**Percentage of total population over 65**
HARROW	15.2
Hillingdon	13.1
Brent	11.5
Kensington and Chelsea	14.9
Ealing	12.1
Westminster	11.8
Hounslow	11.5
Hammersmith and Fulham	10.5

Source: ONS projections - 2016

Harrow has seen an increase in the number of older residents since 2011. The population of those aged 65 and over was 14.1% and this increased to 15.2% in 2016. High proportions of older residents live in the wards to the north. Stanmore Park has the highest proportion of people over the age of 65, with 23.5%. Roxbourne, Greenhill, Marlborough and Wealdstone have fewer than 12% of older residents over 65. The north of the borough has a higher percentage of elderly residents than the south and central areas of the borough (Source: ONS projections **2016**).

Percentage of elderly residents across Harrow's electoral wards.

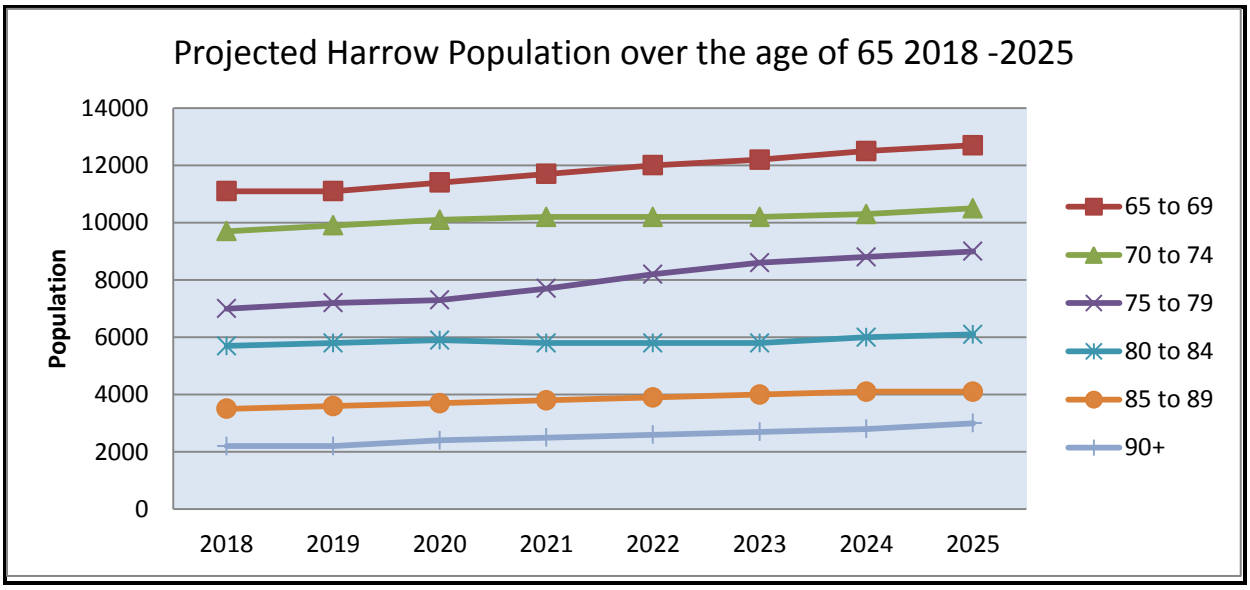
Residents Aged 65+ *Source: ONS LSOA Mid-Year Estimates (2016)*



- Harrow is ranked 7th in London for the proportion of residents aged 65 and over
- 5.2% of Harrows residents are aged 65 and over, 12% (4034 residents) higher since 2011
- Source: Harrow vitality profile 2017-2018

Harrow's elderly population is projected to rise over the next 15 years

The population of over 65s is projected to increase to 45,500. Rises will be seen in all age groups over the age of 65 between 2018 and 2025. This increase in population will impact on the number of people with dementia



Source – GLA intelligence Unit- Released in July 2017

Estimated Dementia Prevalence (65+ only) NHS England Dementia Rate Denominator

July 2018	**Monthly Dementia Diagnosis Rate Indicator**	**Sum of Dementia Registers (65 + only) latest available Numerator**	**Estimated Dementia Prevalence (65 + only) CFAS II Denominator**
England	67.8%	441,626	**651,772**
London	70.8%	47,863	**67,617**
NHS Brent CCG	74.9%	1,846	**2,464**
NHS Central London (Westminster) CCG	73.4%	1,044	**1,422**
NHS Ealing CCG	76.1%	2,211	**2,904**
NHS Hammersmith and Fulham CCG	66.8%	839	**1,256**
NHS Harrow CCG	63.0%	1,589	**2,524**
NHS Hillingdon CCG	66.9%	1,814	**2,711**
NHS Hounslow CCG	71.1%	1,469	**2,065**
NHS West London CCG	75.7%	1,338	**1,767**

(Source: NHS England **July 2018**)

Dementia cases recorded on the GP register

In July 2018, 1,589 people aged 65 and over had been diagnosed with dementia. It is estimated that 2,524 people are living with dementia in Harrow. When applying the Dementia Diagnosis Rate shows Harrow as 63.0%. The denominator used estimates there are 2,524 patients currently living with dementia in Harrow. This forecast suggests there are over 935 people with dementia in Harrow who have not yet been diagnosed, or whose condition is not known to their GP. (Source: NHSE July 2018).

Estimated prevalence of late-onset dementia in Harrow by age group

Age group	Estimated prevalence of dementia in Harrow
Over 65 years of age	1 in 14 people
Over 80 years of age	1 in 6 people
Over 90 years of age	nearly 1 in 3 people

Source: Mental Health Observatory

Consensus of Estimate of population prevalence of late on-set of dementia

Age in Years	Female	Male	Total
65-69	1.8%	1.5%	1.7%
70-74	3.0%	3.1%	3.0%
75-79	6.6%	5.3%	6.0%
80-84	11.7%	10.3%	11.1%
85-89	20.2%	15.1%	18.3%
90-94	33.0%	22.6%	29.9%
95+	44.2%	28.8%	41.1%

NHSE – May 2018

The prevalence of late-onset dementia is greater in females than in males

The prevalence of dementia in females over the age of 65 in Harrow is estimated as 8.2% compared to 6.1% for males. This equates to a total of 1458 females with late onset dementia in Harrow compared to only 829 males. The higher prevalence rate in females can largely be explained by the fact that women have a longer life expectancy

and so are more likely to live into their 80s and 90s, when dementia is most prevalent. However, even allowing for age, Alzheimer's disease is thought to be slightly more common in females than in males. One of the main reasons for the greater prevalence of dementia among women is the longer life expectancy of women (Alzheimer's Research UK / Dementia Statistic Hub **July 2018**)

Prevalence of early-onset dementia

In early-onset dementia, symptoms start below the age of 65. Dementias that affect younger people is said to be rare and difficult to recognise. People are likely to be very reluctant to accept there is anything wrong when they are otherwise fit and well and they may refuse to be diagnosed as a consequence. It is estimated that there are 42,325 people in the UK who have been diagnosed with early-onset dementia. They represent around 5% of the 850,000 people with dementia.

Prevalence rates for early-onset dementia in black and minority ethnic groups are higher than for the population as a whole. People from BAME backgrounds are less likely to receive a diagnosis or support, this is due to some cultural belief and the stigma associated with dementia.

Studies have shown that people with a learning disability are at greater risk of developing dementia at a younger age and that one in ten people with a learning disability develop early-onset Alzheimer's disease between the ages of 50 to 65.

One in ten aged 40-49 and one in three people with Down's syndrome will have Alzheimer's in their 50s (Source -Dementia UK, 2nd edition **2014**, Alzheimer's; Young Dementia UK).

Dementia and Ethnicity in Harrow

Harrow has one of the most diverse populations nationally.

Population estimates for 2017 from ONS (based on the 2011 census). This is resident population.

White	Asian	Black	Mixed/ Other	Total
113,000	105,000	10,000	25,000	252,000
45%	42%	4%	10%	

https://data.london.gov.uk/dataset/ethnic-groups-borough

The number of people registered with Harrow GP practices aged 65 years or older: **38,892 people.** (Patient demographic services extracts for Sept 2018). This is **GP registered** population not comparable with the figures for ethnicity from ONS above.

The largest BAME group is of Indian ethnicity. Research has shown that the borough has the largest concentration of Sri Lankan Tamils in the UK as well as having the highest density of Gujarati Hindus in the UK. The borough is also ranked the 8th nationally for linguistic diversity in the Greater London Authority.

Life expectancy within the borough at 81.2 for men and 84.6 for women is better than that of England as a whole.

The population of those aged 65 and over is 37,701 equalling 15.2% of the total population.

Studies in South Asian communities in Britain have shown there is a sense of stigma and inadequate knowledge about dementia care. This poses a great problem with diagnosis. People tend to put off going to get a diagnosis and this is a big challenge in Harrow.

STRATEGIC IMPROVEMENT AND INTERVENTIONS

Integrated care

The NHS Five Year Forward View (2014) called for new care models to achieve better integration of care across GP, community health, mental health and hospital services, as well as more joined up working with home care, care homes and the voluntary sector.

These new models will be delivered in Harrow through the development of Integrated Care where health and care partners work together to develop models of care that meet the needs of their population. This includes tackling wider determinants of health and illness e.g. housing, environment, education etc.

Integrated care operates through working collectively to a single contract, a shared and single set of outcomes to be delivered and single funding stream for the services delivered. Early results from parts of the country that have started doing this – 'vanguard' areas – are seeing slower growth in emergency hospitalisations and less time spent in hospital compared to the rest of the country. The difference has been particularly noticeable for people over 75, who often face a revolving door of emergency admission, delayed discharge and then hospital re-admission.

Since August 2017, Harrow Clinical Commissioning Group, the Local Authority and key Providers in Harrow have been working in partnership to develop and deliver integrated care initially for a subset of older adults, one group being the 65+ with dementia.

The aim is to enable truly person-centred care that supports adults with significant needs to achieve the best possible quality of life with an increased focus on prevention, proactive care and self-reliance.

The programme aims to ensure that people have a personalised and co-ordinated approach for the care they need, making it easier and simpler to access support. It is intended that from 1st April 2019, Harrow CCG will commission a new model of care and services for this group of over 65's from a provider partnership. The intention is that this new model of care will be designed during September and October 2018, with testing from November 2018.

Care Home projects

North West London collaborative older peoples team are leading on the implementation on a series of schemes across all boroughs in North West London, with individual CCG Care Home leads taking forward the implementation of the projects locally, these projects include:

1. **Red Bag Scheme** is currently available in 13 Harrow older peoples care homes. The aim of the red bag is to streamline information sharing when a patient is transferred into A&E or via a frailty pathway. The vision is for all of older peoples care homes to implement the red bag scheme within the next 6 months.

2. **Telemedicine via 111 *6.** In November 2017 111/*6 was soft launched across NW London, whereby care home staff could speak to a clinician via the 111 service. The service is about to be re launched ahead of winter 18/19 to ensure all care homes are aware of the service to reduce inappropriate LAS call outs and conveyances. Older peoples nurse practitioners are now available 8am-8pm 7 days per week to take the calls, with a view to extend the opening times to 2am over the next few months.

   The overall vision is for telemedicine to be available via 111 *6 in all older peoples care homes, whereby the 111 clinician will be able to complete a consultation as care homes will have access to a tablet device. This pilot will be tested first in a Brent care home with a Harrow care home being tested within the next few months.

3. **Recognising and acting on deterioration Training.** This is a 5 day training programme which is being delivered by St Luke's Hospice to a number of Harrow older peoples care homes. The training is bespoke to each care home and aims

to improve the outcomes in care homes in recognising deterioration and end of life.

4. **Medicines Optimisation in Care Homes** Harrow CCG are one of four CCG's in NW London who expressed an interest in implementing the 2 year pilot. Whereby pharmacists will support care homes with medicines managements and complete medication reviews working closely with the relevant GP's. Harrow CCG are working in partnership with LNWHT, who will recruit and manage the pharmacists. This pilot is due to commence by January 2019 and will initially run for 2 years.

5. **Leadership training programme – My Home Life** All care home managers were invited to apply to take part in the training programme. For Harrow there are 13 care homes that are part of the training programme which is provided by City University. The training is due to end in March 2019 and

Dementia awareness training for staff

Training and educating staff in Dementia Core skills will improve staff knowledge, skills, attitude and confidence and this can have a positive impact on those they provide care. The framework is a comprehensive resource to support health and social care staff, educators and carers who work with and care for people living with dementia. It sets out the essential skills and knowledge necessary for all staff involved in the dementia care pathway. Harrow CCG has commenced training for GP practice and would expect all staff that comes into contact with patients who have dementia to at least attain Tier (1).

Dementia Awareness: Summary of framework subjects

Subject	Tier 1	Tier 2	Tier 3
Dementia awareness	●	●	●
Dementia identification, assessment and diagnosis		●	●
Dementia risk reduction and prevention		●	●
Person-centred dementia care		●	●
Communication, interaction and behaviour in dementia care		●	●
Health and wellbeing in dementia care		●	●
Pharmacological interventions in dementia care		●	●
Living well with dementia and promoting independence		●	●
Families and carers as partners in dementia care		●	●
Equality diversity and inclusion in dementia care		●	●
Law, ethics and safeguarding in dementia care		●	●
End of life dementia care		●	●
Research and evidence-based practice in dementia care		●	●
Leadership in transforming dementia care			●

Delivering the 2020 Roadmap (Prime Minister's Challenge on Dementia)

Key points of the action plan are taken as commitments for local focus in Harrow. The full list of actions at a national level can be seen on-line at: https://www.gov.uk/government/publications/prime-ministers-challenge-on-dementia-2020/prime-ministers-challenge-on-dementia-2020

	Commitments for local focus in Harrow	**Delivery Plan**
1	Improved public awareness and understanding of the factors, which increase the risk of developing dementia and how people can reduce their risk by living more healthily. This should include a focus on health inequalities, a new healthy ageing campaign and access to tools such as a personalised risk assessment calculator as part of the NHS Health Check.	**June 2019**
3	People with dementia having equal access to diagnosis as for other conditions, with an expectation that the national average for an initial assessment should be 6 weeks following a referral from a GP (where clinically appropriate), and that no one should be waiting several months for an initial assessment of dementia	**Done**
4	All Clinical Commissioning Groups and Local Health and Wellbeing Boards having access to improved data regarding the prevalence of dementia at local and national level and using this data to inform the commissioning and provision of services so that more people with dementia receive a timely diagnosis and appropriate post diagnosis support.	**Done**
5	An increase in the numbers of people of Black, Asian and Minority Ethnic origin and other seldom heard groups who receive a diagnosis of dementia, enabled through greater use by health professionals of diagnostic tools that are linguistically or culturally appropriate	**June 2019**
7	GPs playing a leading role in ensuring coordination and continuity of care for people with dementia, as part of the existing commitment that from 1 April 2015 everyone will have access to a named GP with overall responsibility and oversight for their care	**Done**
8	Every person diagnosed with dementia having meaningful care following their diagnosis, which supports them and those around them, with meaningful care being in accordance with published National Institute for Health and Care Excellence (NICE) Quality Standards.	**October 2019**
10	Increased numbers of people with dementia being able to live longer in their own homes when it is in their interests to do so, with a greater focus on independent living	**March 2020**

Views of Key Stakeholders

Harrow CCG undertook a Dementia RightCare 'Optimal Design Workshop' in September 2016. The feedback is included below which has informed delivery to-date and will continue to form part of the delivery plan going forward.

Dementia RightCare - Optimal Design Workshop Feedback from stakeholders event held on 7 September 2016				
	What, if any, changes were suggested by the group	**How should these suggested changes be implemented**	**What, if any, resources or information are required to implement suggested changes**	**What could be the impact of these suggested changes**
Preventing Well	▪ Early identification and risk scoring with 30's, 40's and 50's amongst high risk groups; ▪ Parkinson's, vascular risks; ▪ Current drugs of value? ▪ Better to focus on awareness and trigger points i.e. age group; ▪ Having a stand-alone memory service for people to independently access support where necessary.	▪ Wider stakeholder engagement and awareness raising; ▪ Strengthen link between research and practice; ▪ More support available in the community to tackle social barrier and stigma; ▪ Better support systems to promote healthy living and independence; ▪ Work with employers to raise awareness and enhance support system.	▪ More investment on awareness raising; ▪ High vascular risk prevention; ▪ More social care focus on prevention.	▪ Early identification; ▪ Early detection; ▪ Intergenerational work.
Diagnosing Well	▪ A link worker to support patients and carers throughout their journey e.g. highly skilled Admiral Nurses or Enhanced Practice Nurses to ensure a person-centred and individualised care; ▪ Memory Assessment Service to provide support pre and post diagnosis; ▪ More coordinated and integrated care involving social care and the voluntary sector in supporting patients and families with a dementia diagnosis; ▪ **Please refer to flowchart for suggested framework.**	▪ Develop care pathway for those at high risk of developing dementia; ▪ Develop and maintain robust process of communication amongst professionals; ▪ Recruit or make use of nurses to take on the role of link workers to coordinate patient care throughout their journey; ▪ Provide regular health checks and dementia screening for those at risk and with long-term conditions; ▪ Enhance existing Memory Assessment Service to support patients pre and post-diagnosis.	▪ Tailored training for healthcare professionals to raise awareness and understanding of the pathway; ▪ Create capacity to restructure the pathway; ▪ A system for health professionals to communicate, integrate and coordinate care; ▪ Better use and support from community services and voluntary sectors.	▪ Improved diagnosis; ▪ Early detection and more tailored intervention; ▪ Better support offered to patients and carers; ▪ Coordinated and person centred care and support provided; ▪ Improved value to the population of Harrow.

Living Well with Dementia and Planning ahead	▪ Use of Admiral Nurses for advice, practical and emotional support as early as possible; ▪ Integrate services and support available in the community; ▪ Information, advice and support more readily available to patients, carers and professionals; ▪ Mapped services and pathway to allow carers and professionals to navigate the care and health system; ▪ Involvement of carers and case manager in planning for the future and preparing for future eventualities; ▪ Advice and support available early enough to support patients' and their families to plan ahead and prepare for the future.	▪ Package of care/support agreed and formulated with carers and reviewed regularly; ▪ Care package coordinated by the care navigator; ▪ Care coordinated similar to the care principles of 'palliative care'; ▪ Develop and promote services and support in the community to help patients and carers feel valued and safe in society; ▪ Raise awareness of carers' rights and improve signposting to access legal and financial advice. ▪ Social services and health provide more coordinated care and support; ▪ Use of peer support i.e. patient or carers led; ▪ Enhance pathway to support carers' health and well-being.	▪ More widespread information about the resources and support available to patients and carers; ▪ A database or system that coordinate social care, health care and voluntary sector agencies. ▪ Support to facilitate access to appropriate services; ▪ Innovative models of care and more evidence base; ▪ More therapeutic models of care for patients and carers.	▪ A more positive journey for patients with dementia and their carers/ families; ▪ Carers and patients receive the support they need at the right time; ▪ Reduced levels of stress and worries for patients, carers and families; ▪ Patients and carers feeling more in control of their lives and condition; ▪ Higher number of people accessing appropriate support; ▪ Improved well-being of patients' and their carers and families; ▪ Possible reduction on prescribing.
Supporting Well and Preventing and Managing Crisis	▪ A system analogous to Macmillan Cancer support where care and support is available from diagnosis through to palliative care.▪ Adopt Admiral Nurse model as shown to work well;▪ Care reviews to be triggered by events rather than annual;▪ Reviews best carried out by case manager to ensure continuity of care;▪ Proactively change care and support provided according to patients' changing needs and 'trigger events' such as admission into acute settings, change in social circumstances; co-morbidities;▪ 24/7 crisis hotline for family and carers.	▪ Develop way to identify trigger points for a change in care / management needs to be identified;▪ Education and support for patients, family, carers and professionals to help identify subtle trends and changes;▪ Carers supported to become partners in care;▪ Support people with dementia and their families and carers to live well with dementia;▪ Ensure family and carers' needs are addressed and support to ensure patient well-being;▪ Entry into service provision should be based on needs rather than a diagnostic label.	▪ Create capacity in the system to provide flexible care to support patients' changing needs and late diagnosis;▪ Training and education to carers and professionals;▪ A system for health and care professionals to communicate and coordinate care according to patients changing needs;▪ Nurses to coordinate patient care ;▪ Better use of voluntary sector and social services to provide support to patients and their families and carers.	▪ Continuity of care and support to patients and family carers;▪ Improved emotional and practical support offered to patients and carers;▪ Carers supported and better able to manage and prevent crisis admission.▪ Carers supported and better able to improve patients' well-being;▪ Tailored care and support provided according to changing needs of patients and carers;▪ Improved and timely access to appropriate services by patients and carers;

Dying Well with Dementia	▪ Risk stratification tool to identify multiple admissions and reduced levels of functioning; ▪ A first point of contact (i.e. 'Dementia Adviser' to carry out regular reviews, care coordination/navigation and emotional support; ▪ Access to menu of support/ability to refer; ▪ Personalised and flexible care plans owned by patients and carers with rights of access and determination between carer and patient clearly outlined; ▪ Proactive care plans that clearly describe agreed provision of care and support to empower patients and carer to achieve personal goals; ▪ Care plans to describe family and social situation and is used by the system; ▪ Emotional and practical support for carers post death.	▪ Regular review of need and care plan with single point of contact (i.e. 'Dementia Adviser' to foster trusted relationship; ▪ 'Dementia Adviser' to develop, manage and review patient/carer owned care plan and support patient and carers; ▪ 'Dementia Adviser' to identify when condition of patient deteriorates or circumstances change to adapt care approach and provide advice and first line emotional support to carers and families. ▪ Pilot Stafford and Cannock's 'Memory First' programme; ▪ Provide separate (and shared) support for patient and carer.	▪ 'Dementia Adviser' to have dementia expertise; local knowledge and awareness of services including cross boundary, cultures and communities; ▪ Alzheimer's Society to provide evidence and information; ▪ Support system that prepare families and patients for end of life and build early plans, some of which would commence at diagnosis (linked with care plan and 'Dementia Adviser') ▪ End-of-life support and education for people with dementia and carers;	▪ Possible reduction in hospital admissions; ▪ Improved support offered and personalised care to patients and carers; ▪ Reduced demand on primary care; ▪ Prevent unnecessary clinical interventions; ▪ Better experience and outcomes for patients and carers;

Where we are now

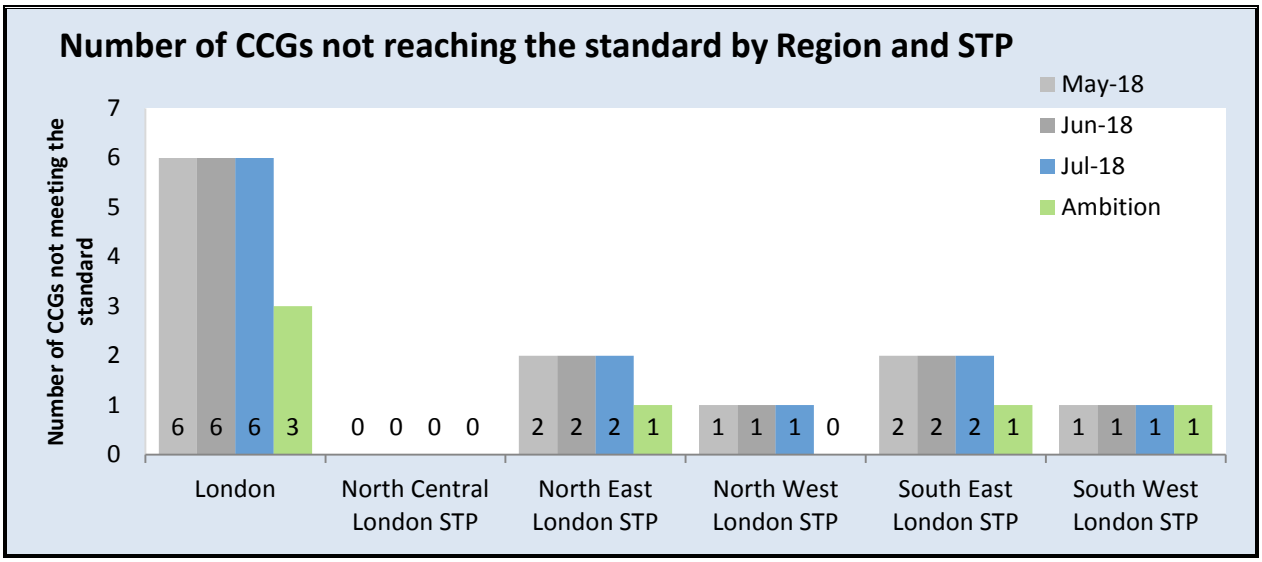
Significant progress has been noted since the 2010 to 2015 strategy and they are as follows:

- Partnership working between the Memory Assessment Service (MAS), GP's, Acute Hospitals, and through referral agencies
- Sign Posting to Voluntary and Community Sector Organisations resource funded and non-resource funded support services in Harrow
- Weekly Local Authority engagement with older people services, CCG and Acute Mental Health services to prevent 'delayed transfers of care' (DToC)
- Co-located social worker based in the team
- A pre-screening tool has been designed for Nursing Home staff to review their patients where dementia is indicated but not diagnosed. This will allow a more focused approach for the MAS and GPs. The screening tool has been shared with the Local Authority to deploy in partnership working with Nursing Homes
- MAS service already participating in reviews of patients in nursing homes
- CNWL and the MAS are training all their staff; 'Make every contact count'
- Harrow Patient Participation Network and CCG Engagement Team are working together to develop a strategy for public engagement to raise awareness and to de-stigmatise dementia.
- Post diagnostic information packs given to all service users and carers which include information on Housing benefits, community transport and various

voluntary and community sector organisations.

Where we want to be

We are doing a lot of work in terms of addressing the stigma and cultural taboo associated with dementia where many families are reluctant to seek help and miss out on health and social care interventions. These include; medication, carer support, advice, family friendly housing, dementia friendly transport, financial help for both carers and users through dementia disability living allowance and carers allowance.



Harrow is on trajectory to meet the Dementia Diagnostic Rate Target of 67% by December 2018.

Harrow CCG Dementia Diagnosis Improvement Plan

- Performance management driven by the Executive team including the Chairman and MD
- Clinical Director for Mental Health has been involved at every level in driving the requirement to increase diagnosis
- Clinical Director leads meetings held with CNWL (MAS) in trying to drive up numbers being diagnosed
- MD engaging with VCSO's including Harrow Patient Participation Network to cascade wider awareness and to seek their support in engaging with users and carers
- Areas of underperformance reviewed regularly at the MDs/CDs where

discussions to assess any additional approaches that can be taken and to quantify the impact of any actions already taken.

- Dementia performance is also discussed at the Finance Recovery Operation Group under the assurance section
- Reports including Dementia performance is reviewed at the Finance & Performance Committee
- Performance against all areas including Dementia is reviewed at the Senior Leadership Team

CCG strategies to deliver the diagnosis ambitions

- Practices have been asked to check the quality outcome framework (QOF) to ensure patients are recorded correctly.
- The message has been repeated in other formats to all GP Practices during 2018
- Harrow CCG is in the process of using an EMIS Specialist to deep-dive ensuring effective cleansing of all registers. Monitoring will be undertaken practice by practice.
- In the letter to GP practices Harrow CCG suggest; practices review all treatment cases on 'GP EMIS' where reversible medications (Acetylcholinesterase inhibitors) are being used for patient not diagnosed with dementia or review how they are being coded. In addition GPs are asked to review their coding for cognitive impairment as in some cases these can be coded as 'Dementia unspecified' (Read Code: Eu02z).
- Harrow CCG will follow up the cleansing with the joint harmonisation work in collaboration with CNWL MAS
- GP practices will receive requests from Harrow CCG to maintain compliance fortnightly, then monthly dependent on outcome
- CNWL (MAS) are undertaking a reconciliation of all diagnosed cases with GP practice record.
- The CCG is supporting CNWL MAS with additional admin staffing to deliver this initiative.
- On completion this should form the basis of a full and 'live' Dementia Register for Harrow
- Harrow MH Commissioners, CNWL, London Borough of Harrow and the Voluntary and Community Sector are developing a strategy for post-diagnostic support. The Dementia Strategy (2018-2020) is due to go to the Harrow Health and Social Care Scrutiny Committee in October 2018
- Support to deliver this is being requested through Faith Groups, Community Networks, Harrow Carers, Harrow Mencap, Harrow Mind, Harrow Patient

Participation network, and Harrow Association of Somali Voluntary Organisations

- Harrow CCG has commissioned an EMIS specialist experienced in uncovering undiagnosed cases to support GP practices with increasing their dementia diagnosis rate.

CONCLUSION

The purpose the strategy is to provide a framework for creating and empowering dementia environment for the people living with dementia and their families. The focus is to help people with dementia needs feel in control of their lives, feel valued and to also help carers feel satisfaction in charge of the disease what they accomplish in care.

The strategy will be subject to scrutiny where potential gaps in the pathway may be identified, as they often are when users, carers, friends and family provide personal stories and experiences. Learning from such comments will help to improve diagnostic and post diagnostic health and social care support for dementia.

The local and national strategic vision is set out to be achieved in the document. Aligning the action plan to deliver it and providing the evidenced will be achieved through partnership working between all stakeholders. Health and Social Care will take the lead as accountability will be monitored through their regulators.

Implementation of the plan has started and the new NICE guidance will provide a measurable framework and toolkit to deliver the best dementia care and support.

This strategy supports the national dementia plan and we are committed to improving dementia care in Harrow.

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

Date of Meeting:	16 October 2018
Subject:	Harrow Safeguarding Adults Board (HSAB) Annual Report 2017/2018
Responsible Officer:	Visva Sathasivam, Interim Director of Adult Social Services
Scrutiny Lead Member area:	Lead Members for People - Councillors Jerry Miles and Janet Mote Lead Members for Health – Councillors Michael Borio and Vina Mithani
Exempt:	No
Wards affected:	All
Enclosures:	Harrow Safeguarding Adults Board Annual Report 2017/2018

Section 1 – Summary and Recommendations

The attached report provides Scrutiny Committee Members with an overview of safeguarding adults activity undertaken in 2017/2018 by the Council and its key partners through the work of the Harrow Safeguarding Adults Board (HSAB). It sets out the progress made against objectives, analyses the referrals received and outlines priorities for the current year (2018/2019).

Recommendations:
Scrutiny Committee is requested to note the work that has taken place in 2017/2018 and the action plan for 2018/2019.

Section 2 – Report

Introductory paragraph

This is the 11th Annual Report of the Harrow Safeguarding Adults Board (HSAB) and a copy is attached as an appendix for information and full details.

Background

Under the Care Act 2014 the local Safeguarding Adults Board has 4 core (statutory) duties. It **must**:

i. publish a strategic plan for each financial year

- *the Harrow SAB has a 3 year strategic plan for 2017 – 2020 which is updated each year after the production of the Board's annual report*

ii. publish an annual report

- *Harrow SAB's 10th Annual Report (for 2016/2017) was presented to the Council's Scrutiny Committee in July 2017. This 11th report covers the financial year 2017/2018*

- *each partner organisation represented at the HSAB presented the Board's Annual Report for last year at their Executive level meeting or equivalent*

- *as in previous years, the Board's annual report for 2017/2018 has been produced in "Executive Summary", "key messages for staff" and "easy to read" formats and is available to a wider audience through the Council and partner agencies websites*

iii. conduct any Safeguarding Adults Reviews (SARs)

- *these will be carried out as required, but there were none commissioned by the HSAB in 2017/2018*

iv. have the following organisations on the Board – the Council; the local NHS Clinical Commissioning Group (CCG) and the chief officer of Police

- *the membership of Harrow's SAB (as at 31st March 2018) is shown in Appendix 2 and their attendance record is shown at Appendix 3*

Statistics

The attached report covers the full range of statistical analysis as well as an update on progress against the objectives set in 2016/2017.

In the majority of the performance statistics in the report, the Harrow position mirrors the last available national data and/or is broadly in line with the 2016/2017 position.

As is the case across the UK, elderly women remain the most at risk group with most abuse taking place at their home. Family or partner are the most likely people alleged to have caused harm.

From analysis of the statistics, areas for the HSAB's attention in 2018/2019 include: (i) more focus on the newer areas of work i.e. modern slavery; forced marriage/sexual exploitation; and domestic abuse so that the HSAB is reassured there is sufficient knowledge amongst professionals about recognition and referral mechanisms; (ii) a continued focus on Police action/criminal prosecution where a crime may have been committed; (iii) ensuring that wherever possible the outcome for the person alleged to have caused harm (PACH) is recorded; (iv) reviewing how information about outcomes for the adult at risk is recorded on Jade and Mosaic so that a wider variety can be reported in future years – in line with Making Safeguarding Personal implementation.

Some examples of HSAB work in 2017/2018

- 1,263 staff across all organisations had some safeguarding adults training last year
- some care providers ran events to mark Dignity Awareness Day (1st February 2018)
- The HSAB and HSCB held their second joint conference in February 2018 with a focus on sexual abuse within the family. Evaluation was almost 100% positive from the 155 multi-agency staff that attended and there is a commitment from both Boards to continue collaborating on events in future years
- The Council's Housing Department highlighted scams and how to keep safe in its "Homing In" magazine sent to all tenants
- The Mind in Harrow e4ducation course programme promoted the Metropolitan Police 'Little Book of Big Scams' section about online scams and has provided a new user-friendly information sheet about safeguarding & Prevent to over 200 people with mental health needs to increase awareness
- Harrow Mencap work with individuals and groups on their rights including their right to report to the police. After a recent hate crime forum one member saw another member being verbally abused in St Ann's Shopping Centre and as a result of the forum recognised this as hate crime and called the police. Harrow Mencap supports individuals to make statements to the police
- There have been a number of "deep dive" statistical reports (looking at an area of safeguarding work in more detail) presented to the HSAB in 2017/2018 – including on domestic abuse and repeat referrals.

  These reports have enabled the Board to take decisions about future work e.g. asking Housing and the voluntary sector to raise awareness with staff about domestic abuse in a safeguarding context due to low numbers of referrals from those areas
- Information was given to local care providers at their forums about fire safety and followed up by the Council's Safeguarding Quality Assurance (SQA) Team in its newsletter
- RNOH runs annual learning at work seminars for patients, stakeholders and staff. During the seminar, all the different directorates such as safeguarding children and adults have stands to provide information

such as 10 Golden Rules to prevent scammers, Independent Mental Capacity Advocates, hoarding, staff contacts, advice and support

- The Council's Safeguarding Quality Assurance (SQA) Team ran a programme of training sessions for care providers in 2017/2018 including: SCIE sessions on dementia/challenging behaviour (80 staff) and Tissue Viability Nurse led sessions about pressure care (90 people)

- CNWL's Liaison Psychiatry Team is accessing training provided by the Hestia Modern Slavery Team. This is to ensure they are up to date on knowing what are the indicators that someone presenting in crisis at an Emergency Dept or admitted to hospital may have (symptoms or injuries) that are due to abuse or neglect as manifestations of domestic abuse, sexual exploitation/trafficking and/or modern slavery

- The Designated Nurse (Adults) at the CCG, together with the NHSE Regional Prevent Coordinator (London) as well as a lead from the General Medical Council delivered training to 30 Harrow General Practitioners about "Raise Awareness of Prevent" (WRAP)

- At London North West Hospitals University NHS Trust domestic abuse awareness has been firmly incorporated into the training provided to Trust staff with two Independent Domestic Violence Advocates (IDVA's) employed in the Emergency Rooms at both Ealing and Northwick Park Hospitals

- Harrow Mencap has delivered learning disability awareness training in schools and led a workshop at the HSAB/HSCB joint conference on sexual abuse and disability.

  Harrow Mencap collaborated with the British Institute of Learning Disability and FPA – the Sexual Health Charity - to facilitate two key programs

- In October 2017 Central London Community Health NHS Trust held its first annual safeguarding conference. This was a day-long conference covering topics on Child Sexual Exploitation (CSE), Mental Capacity Act 2005, Modern Day Slavery and Making Safeguarding Personal

The areas for the Board to action in 2018/2019 include:

- a range of methods are used throughout the year to provide information to all sections of the community with a focus on people/groups highlighted in the statistics (e.g. older people living in their own home and about the risks of financial abuse)

- further attempts are made with Head Teachers to engage with young people and adults at risk – in relation to disability awareness and social inclusion

- relevant awareness campaigns take place each year (e.g. a focus on scams, door step crime, distraction burglary) and formal evaluation influences future activities

- work continues with care providers and the general public about fire safety
- Provider concerns are monitored at Board meetings and commissioners oversee quality assurance
- Providers are supported with relevant information/training
- a minimum of 40 externally audited and 30 internally audited cases will be completed each year; and independent user interviews will take place. The focus will be on ensuring that the outcomes desired by users were identified through a person centred approach to practice (including use of advocates). Audit reports will be taken to the HSAB with any required actions and proposed recommendations
- audit findings, user feedback, Safeguarding Adults Reviews (previously serious case reviews) actions and Risk Panel learning to be fed into the Multi-agency Training Programme and Best Practice Forums
- work continues to take place to increase staff confidence (in all agencies) in completing mental capacity assessments and using DoLS/Court of Protection
- the approach to multi-agency safeguarding adults training to be changed in 2019/2020 – to run more best practice forums and bespoke events (on emerging topics) - with recommendations for future programmes reported to HSAB in March 2020
- projects are implemented as highlighted by users
- HSAB monitors the actions resulting for each agency represented on the Board from the NHS England/ADASS Risk Audit completed in 2017/2018
- a third joint HSCB HSAB conference will be held in 2018/2019 with a focus on “trafficking and modern day slavery”.

Financial Implications

As at 31st March 2018, the staffing of the dedicated Safeguarding Adults and DoLS Service located in the Council is as follows:-

1 Service Manager (Safeguarding Adults and DoLS)
1 DoLS Officer
1 Safeguarding Adults Co-ordinator
1 Team Manager
2 wte Safeguarding Adults Senior Practitioners
6 wte qualified Social Workers; and 1 wte care manager
2.5 wte Best Interest Assessors (DoLS work only)

Under the formal Section 75 agreement there are also a number of trained Safeguarding Adults Managers with a dedicated lead located in Central and North West London Mental Health NHS Foundation Trust (CNWL). The statistics for the CNWL Safeguarding Service are included in section 2.2 of the annual report.

The annual budget for 2018-19 totals £1.130m, of which £0.924m funds staffing costs. In addition to staff, there are ongoing costs for the multi agency training programme; best practice forums; publicity (posters/fliers/wallet cards); awareness/briefing sessions; independent file audit and administrative support to the HSAB etc. The costs of these services are primarily borne by the People Services Department within Harrow Council, with contributions totalling circa £25,000 p.a. from three of the four local NHS partner agencies (Harrow Clinical Commissioning Group; North West London Hospitals Trust; and the Royal National Orthopaedic Hospital Trust); the London Fire Service and Metropolitan Police.

Costs related to the time spent by partner agencies on HSAB activities e.g. attending meetings, facilitating staff release for training etc, are borne by the individual member organisations.

The costs of implementing the HSAB objectives for 2018/2019 are expected to be met within the allocated budgets.

Performance Issues

The attached report is primarily concerned with performance and contains analysis of the Harrow Safeguarding Adults Board statistics, both as they relate to the previous year and (wherever possible) to national data.

Environmental Impact

There is no environmental impact arising from this report.

Risk Management Implications

Risk included on Directorate risk register?	Yes
Separate risk register in place?	No

Potential risks:

Failure to ensure local safeguarding adults' arrangements are robust could lead to a serious untoward incident e.g. death of a vulnerable person. Failure to implement the statutory DoLS guidance could lead to a legal challenge about unlawful deprivation of a vulnerable person in a care home, hospice, or hospital.

Equalities implications

The HSAB considers local safeguarding adults statistics at each Business Meeting and at its annual review/business planning event, with particular emphasis on ensuring that concerns (referrals) are being received from all sections of the community. The Strategic Plan for 2017 - 2020 was developed such that the HSAB monitors the impact of abuse in all parts of Harrow's community. Safeguarding adults' work is already focused on some of the most vulnerable and marginalised residents and the 2017/2018 statistics demonstrate that concerns continue to come from all sections of the Harrow community.

Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

This report primarily relates to the Corporate priorities of:

- making a difference for the vulnerable
- making a difference for communities.

Section 3 - Statutory Officer Clearance

Name: Donna Edwards	x	on behalf of the Chief Financial Officer
Date: 20 September 2018		

Ward Councillors notified:	No - the report affects all Wards

Section 4 - Contact Details and Background Papers

Contact: Visva Sathasivam (Interim Director - Adult Social Services)

Background Papers: Harrow Safeguarding Adults Annual Report 2017/2018 (see enclosure)

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& our Partners,

Committed to Safeguarding Adults

Harrow Safeguarding Adults Board (HSAB)

Annual Report 2017 - 2018

in partnership with:

Index **Page**

"Harrow is a place where adults at risk from harm are safe and empowered to make their own decisions and where safeguarding is everyone's business" (HSAB Vision)

Foreword

I am delighted to have taken over as the Harrow Safeguarding Adults Board (HSAB) chair and would like to thank staff, volunteers, experts by experience, users and carers from all agencies who have contributed to safeguarding and dignity/respect work in Harrow over the last year.

The second joint HSAB HSCB (Harrow Safeguarding Children's Board) annual conference took place on 2nd February 2018 with a focus on sexual abuse within the family. It was an excellent day with inspirational speakers and challenging workshops and continued to develop both Boards' commitment to "thinking whole family". We hope to run our third event in early 2019 on a topic that once again affects both children and adults with care/support needs who may be at risk of harm.

A priority for the HSAB last year was more specific projects to tackle issues such as hate crime; scams; distraction burglary/doorstop crime; and home fire safety. Section 3 highlights the excellent work that has been done by partners in these areas over the last 12 months.

As in previous years, the Board has provided training to a very large number of people and I was particularly pleased that 88 staff from a wide range of partner organisations attended our Best Practice Forum on scams and fraud which was run to mark World Elder Abuse Awareness Day 2017.

I think that once again this annual report demonstrates the difference that the Board's work has made to the lives of the most vulnerable people in the borough and hope you agree once you have read it.

As ever, everything the HSAB does is to achieve its vision – "*that Harrow is a place where adults at risk from harm are safe and empowered to make their own decisions and where safeguarding is everyone's business".* In that context, section 4 of this report covers the areas that the Board wants to focus on this year (2018 – 2019) which includes more training and support for everyone in recognising the newer areas of abuse, (for example modern slavery) and knowing how to report it.

I am delighted to present this report to you and hope you will use it to raise awareness of adult safeguarding and to identify issues that you can take forward in your own organisation.

Visva Sathasivam (Chair of the HSAB)

SECTION 1 - INTRODUCTION

1. Introduction to the annual report

This is the 11th Annual Report published on behalf of Harrow's Safeguarding Adults Board (HSAB) and contains contributions from its member agencies. The Board is statutory and coordinates local partnership arrangements to safeguard adults at risk of harm. This report details the work carried out by the HSAB last year (2017/2018) and highlights the priorities for 2018/2019.

The Care Act 2014 set out the main purpose of a safeguarding adults board as:

- to assure itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance;
- to assure itself that safeguarding practice is person-centred and outcome-focused;
- to work collaboratively to prevent abuse and neglect where possible;
- to ensure agencies and individuals give timely and proportionate responses when abuse or neglect have occurred;
- to assure itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in Harrow

1.1 The Harrow Safeguarding Adults Board (HSAB)

The Harrow Safeguarding Adults Board (HSAB) is chaired by Visva Sathasivam (Director – Adult Social Services, Harrow Council) and is the statutory body that oversees how organisations across Harrow work together to safeguard or protect adults with care/support needs.

The HSAB takes its leadership role very seriously with appropriate senior management attendance from member organisations and the active involvement of the elected Councillor who is the Council's Portfolio holder for adult social care, health and well-being. The list of members (as at March 31st 2018) is at Appendix 2, with their attendance record at Appendix 3.

1.2 HSAB Accountability

Under the Care Act 2014 the HSAB has core duties. It **must**:

i. publish a strategic plan for each financial year

- the HSAB has a 3 year strategic plan for 2017 - 2020 which is updated each year after production of the annual report

ii. publish an annual report

- the HSAB's 10th Annual Report (for 2016/2017) was presented to the Council's Scrutiny Committee on 3rd July 2017 and this 11th report for 2017/2018 will go to a Scrutiny meeting on 16th October 2018

- each partner organisation represented at the HSAB presented the Board's Annual Report for last year at their Executive level meeting or equivalent
- as in previous years, this report will be produced in "Executive Summary", "key messages for staff" and "easy to read" formats and will be available to a wider audience through the Council and partner agencies websites

iii. conduct any Safeguarding Adults Reviews (SARs)

- the HSAB has an agreed protocol for carrying out Safeguarding Adults Reviews, but no referrals were received requesting a SAR in 2017/2018

iv. have the following organisations on the Board – the Council; the local NHS Clinical Commissioning Group (CCG) and the chief officer of Police

- the membership of Harrow's HSAB (as at 31st March 2018) is shown in Appendix 2 and their attendance record is shown at Appendix 3

1.3 Strategic Links

The HSAB has links with the following partnerships also working with communities in Harrow, to help the Board ensure that local arrangements are effective in protecting people with care and support needs from the experiences or risk of abuse and neglect: *Health and Wellbeing Board; Harrow Safeguarding Children's Board (HSCB); Safer Harrow Partnership; Domestic Abuse Forum; Multi-Agency Risk Assessment Conference (MARAC); Multi-agency Public Protection Arrangements (MAPPA) and Prevent*.

1.4 "London Multi-Agency Adult Safeguarding Policy and Procedures"

The final version of the London Multi-Agency Adult Safeguarding Policy and Procedures was implemented by the Harrow Safeguarding Adults Board from 1st April 2016 and has been used throughout the period covered by this report.

SECTION 2

HSAB Work Programme in 2017/2018

2.1 Harrow HSAB business meetings – work areas covered

The HSAB met on 4 occasions in 2017/2018 – three Business Meetings and an Annual Review/Business Planning Day. The following table lists the main topics discussed by the Board at those meetings – some being standing items; some were items for a decision; some were for information/discussion; others were aimed at Board development, and there were also specific items providing challenge to the Board. Some items were discussed at more than one meeting.

Prevention and Community Engagement (including user involvement)

- "ordinary lives are safer lives" – experts by experience input to annual review/business planning day 2017 (item for challenge)
- "feedback about keeping people with mental health problems safe" - experts by experience input to annual review/business planning day 2017 (item for challenge)
- World Elder Abuse Awareness Day 2017 in Harrow – local arrangements agreed (item for decision)
- hoarding (item for information/Board development)
- Violence, Vulnerability and Exploitation (VVE) Strategy – (item for information/Board development)
- user outcomes – feedback from independent file audits and interviews with users (item for information)
- Best Practice Forum on 15th June 2017 – "scams, fraud and staying safe" (item for information)
- revised Prevention Strategy for 2017 – 2020 (item for decision)
- fire safety in care homes (item for information, Board development and action)
- Provider concerns (item for information at every meeting)

Training and Workforce Development

- HSAB training programme for 2018/2019 (item for information and decision)
- feedback from the joint HSAB/HSCB conference on 2nd February 2018 (item for information)
- learning from joint HSAB/HSCB "whole family" case audits (item for discussion)

Quality and Performance Review

- quarterly statistics – discussed and findings used by the HSAB to inform changes to the training programme and local practice (standing item at every meeting)
- statistical "deep dive" reports – on domestic abuse; repeat referrals and financial abuse (items for information, discussion and decisions)
- Deprivation of Liberty Safeguards (DoLS) statistics (item for information and discussion)
- "critical friend" review of Council safeguarding arrangements by Professor Jill Manthorpe (item for challenge, discussion and information)
- mystery shopping exercise – (item for information and decision)
- learning from a domestic homicide review (item for information and discussion)
- learning from the Mendip House Safeguarding Adults Review (item for information and discussion)
- ADASS risk assessment tool (item for decision and action)

Policies and Procedures/Governance

- HSAB Strategic Plan 2017/2020 – (item for decision)
- HSAB Annual Report 2016/2017 - discussed and formally signed off (item for decision)
- Making Safeguarding Personal (MSP) – position statement for London SAB (item for decision)
- Metropolitan Police information sharing agreement (item for discussion)
- Metropolitan Police changes (item for information)
- Appropriate Adult protocol (item for discussion)
- Supporting development of the London SAB (item for decision)

Joint work with the Harrow Safeguarding Children's Board (HSCB)

- HSCB Annual Report 2016/2017 (item for information and discussion)
- feedback from HSCB HSAB joint file audits (item for information and discussion)

Safeguarding Adults Reviews (SARs)

No referrals were made to the HSAB requesting that a SAR be commissioned during 2017/2018, however the Board did receive a report on the Mendip House SAR and debated any transferable learning.

2.2 Management information (statistics)

The Board collates multi agency information on a range of adult safeguarding statistics in order to produce a management report. The report which is available at each business meeting is overseen by and discussed at the HSAB. The Board's strategic plan for 2017 – 2020 contains 5 year trend analysis which provides an excellent basis for planning future work. The 3 year trends post the implementation of the Care Act 2014 are shown at Appendix 1 and referred to in the narrative below.

The background information for the statistical analysis of safeguarding adults services work in 2017/2018 is available on request.

Headline messages 2017/2018 – safeguarding adults

- 1,467 concerns compared to 1,662 in 2016/2017, represented an 11% reduction. There had been a year on year rise in referrals from 2009/2010 which indicated that more professionals were identifying abuse/neglect and how to report it. There then followed a 38% rise in concerns for the financial year 2015/2016 due to the threshold being lowered and widened with Care Act 2014 implementation. The Harrow SAB will continue to monitor referral numbers to be reassured that cases of abuse are being reported appropriately

- 43% of Harrow concerns were taken forward as enquiries, compared to 39% in 2016/2017. The most recent national comparator is 41%, so the HSAB can be reassured that locally a very similar number of concerns have met the threshold for enquiries. However, as previously reported, both internal and external file audits continue to check that appropriate concerns are being taken forward to the enquiries stage i.e. that threshold decisions are being correctly made in the safeguarding adults teams

- repeat enquiries in Harrow had increased again from 19% in 2015/2016 to 31% in 2016/2017. Consequently the HSAB requested and received a report during 2017/18 which looked in detail at the cases referred more than once into the Council's Safeguarding Service.

  With two exceptions the Board was reassured to find that all the repeat referrals were not as a result of inaction or inappropriate action by the LBH SGA Team. There was also evidence of care management involvement in parallel to safeguarding enquiries which is appropriate given the complexity and risk with a number of the cases. Where 2 cases required escalation it was reassuring to find that the Team Manager immediately saw the need for enquiries and allocated accordingly.

  The audit highlighted the need for ongoing support and training for staff in mental capacity assessments where risks are high due to perceived unwise decision making. A best practice forum is being planned for summer 2018 with the key note speaker having carried out several recent SARs in cases where mental capacity assessments were challenging and also where legislation outside that commonly used in social care would have been appropriate e.g. through the Police, Housing or Environmental Health. A number of audited cases needed progression to the Court of Protection – another area of training being given high priority for LBH staff.

  It is noteworthy that in 2017/2018 repeat enquiries dropped back to 17% (the average over the 6 years prior to 2016/17 having been 11%), however it will remain an area that is kept under close review by the Board. The most recent national comparator figure was 28%

- completed enquiries in Harrow were at 99% last year, suggesting that casework is progressing to a conclusion and not "drifting"

- in Harrow the female:male ratio at the end of 2017/2018 was 60:39 for enquiries, which is relatively close to the figure in 2016/2017 of 67:33. Nationally the percentage of women subject to safeguarding adults enquires also remains higher than for men (60:40) and the ratio in Harrow has been fairly stable since the statistics were first collected

- the figure for older people remains identical at 48% (301 people in 2017/18 compared to 317 in 2016/17) and they continue to be the highest "at risk" group as they have been since 2009/2010. Nationally older people represented 63% of the concerns

- for adults with a physical disability the figure in Harrow last year was 34% of concerns (217 people) compared to 38% in 2016/2017. As indicated in previous annual reports it is important to note that in the statistics (as required by the Department of Health/NHS Information Centre), people (for example) who are older but also have a physical disability are counted in both categories.

It therefore remains quite difficult for the HSAB to form a view about the risks to younger adults whose primary disability is physical or sensory

- mental health numbers were 31% last year, having increased over the previous 2 years from 16% in 2014/15 (which was significantly below the national average) to 33% in 2016/17. Numbers now seem to have stabilised at a figure above the most recent national average of 21%
- in Harrow enquiries for people with a learning disability in 2017/2018 were slightly higher (80 people) than the previous year's figure of 71, but numbers remain relatively stable – the average over the last 7 years being 17% (compared to 13% in 2017/18). The most recent national figure is 13%r
- concerns from "BME" communities last year were at 51% compared to 48% in 2016/2017 – which remains in line with the makeup of the Harrow adult population. The enquiries figure was 46% which is also positive, as it suggests that a proportionate number of concerns progress and concerns from "minority" communities are not disproportionately closed before that stage of the process

- statistics showing where the abuse took place in Harrow remain broadly similar to 2016/2017. The highest percentage at 57% is in the user's own home, compared to the average over the last 7 years of 55%. Concerns for care homes rose slightly last year (from 14% to 19%), however the numbers have stayed relatively stable with the average figure over the previous 7 years being 23%. The national statistics are in similar proportions i.e. highest levels of abuse in the user's own home (44%), but show higher numbers in care homes (36%)

  Numbers in other settings were - 5% in mental health in-patient units (30 patients compared to 38 in 2016/17); 5% in supported accommodation (33 people compared to 51 in 2016/2017); 5% (30 incidents) in a public place; and 2% in acute hospitals (10 patients compared to 5 the previous year)

- allegations of physical abuse, neglect, emotional abuse and financial abuse have been the most common referral reasons in previous years and reported in successive annual reports. It is therefore possible to compare the 2017/2018 statistics with the average figures from the last 7 years.

  Physical abuse was 19% last year compared to the average of 24%. Neglect was at 22% in 2017/18 compared to the average of 20%. Emotional abuse was at 20% which is exactly the same figure as the average over the last 7 years. Financial abuse was at 19% last year compared to the average of 17% and has been growing in numbers over the last few years.

The following areas can be compared to 2016/2017:

- sexual abuse at 5% (43 people) compared to 7% (60 people)
- concerns about self-neglect which rose again from 14 situations to 28 being dealt with under the local arrangements
- concerns about domestic abuse also rose from 75 people to 86 people
- the newer area of modern slavery rose from nil in 2016/17 to 4 cases last year

There were no reported cases of forced marriage or sexual exploitation last year.

- in Harrow, social care staff (21% across all care sectors); family/partner (41%); stranger (5%); and health care worker (5%) were the most commonly alleged persons alleged to have caused harm (PACH). These figures were largely in line with 2016/2017 with the exception of family/partner which increased by 6%, having already been the highest category in recent years
- given the numbers of training and briefing sessions undertaken in recent years, it is always important to look at the source of concerns and this is the fourth time that year on year comparison has been possible for the HSAB to carry out:

  Last year the highest numbers (18%) were from social workers/care managers; mental health staff and primary health care staff (13%); secondary health care staff (12%); and Police (10%). The other sources were: residential care staff (7%); family (7%); self referral (3%); and Care Quality Commission (2%). There are no significant statistical changes from the previous year
- outcomes in Harrow for the person alleged to have caused harm in relation to criminal prosecutions/Police action compared to the 2016/17 statistics of 131 cases have decreased again to 105 (14%) – which is disappointing given the amount of focus on this area in the last 2 years. The safeguarding adults teams in both the Council and CNWL MH Trust supported by the Police will continue to give this area a high priority.

  Other outcomes for the PACH were: exoneration (13%); monitoring (6%); management of access to adult at risk (8%); and community care services (6%). There were 154 cases where the outcome was “not known” (primarily in the Council’s service) which is disappointing and will need to be an area of focus in 2018/19
- outcomes for the adult at risk include: community care assessment and services at 20% (up 3%); increased monitoring at 12% (down 1%); management of access to PACH at 6% (up 1%); moved to different services at 7% (up 2%); and referral to advocacy at 2% (down 1%). Referral to counselling or training at 2%; referral to MARAC at 1%; management of access to finances at 3%; and application to Court of Protection were all the same as last year’s figures.

There were 252 outcomes recorded as “other” which in the context of Making Safeguarding Personal suggests that the Mosaic and Jade recording systems may not be picking up the more varied solutions which people are seeking.

Summary/Actions Required

In the majority of the performance statistics above, there is now quite a lot of stability in comparison to previous years. Also, although most areas are not significantly different from the national picture the actions below have been developed in the context of the national comparator data. Areas for focus in 2018/2019 include:

- a focus on the newer areas of work i.e. modern slavery; forced marriage/sexual exploitation; and domestic abuse so that the HSAB is reassured there is sufficient knowledge amongst professionals about recognition and referral mechanisms
- a continued focus on Police action/criminal prosecution where a crime may have been committed
- ensuring that wherever possible the outcome for the PACH is recorded
- reviewing how information about outcomes for the adult at risk is recorded on Jade and Mosaic so that a wider variety can be reported in future years – in line with Making Safeguarding Personal implementation

The plan in section 4 of this report (year 2 of the HSAB Strategic Plan 2017 - 2020) includes actions to address the key messages from the statistical analysis.

Headline messages - Deprivation of Liberty Safeguards (DOLS) 2017/2018

This is the fourth year that the HSAB Annual Report has included statistics for use of the Deprivation of Liberty Safeguards (DoLS). These are relevant for people in hospitals, hospices and care homes who lack the mental capacity to understand and consent to the care/support they need and in particular to any restrictions e.g. locked front doors and/or medication given covertly. The use of these safeguards is important in the Board's oversight of the prevention of abuse as they are relevant for some of the most vulnerable people known to local services (including those that are placed out of borough) and the HSAB needs to be reassured that they are carefully applied and monitored.

The Law Commission review of the DoLS was reported in Spring 2017 and suggests that the current arrangements may be replaced by Liberty Protection Safeguards. It is unclear when the change will be required, however the action plan at Section 4 refers to any possible preparatory work needed.

	Total Active Cases	**Granted**	**Granted (%)**	**Not Granted**	**Not Granted (%)**	**Withdrawn**	**Yet to be signed off**
2017/18	**1078** (725)	**684**	94%	**35**	5%	**6 (1%)**	**353**
2016/17	957	893	93%	51	6%	13 (1%)	0
2015/16	778	644	83%	88	11%	46 (6%)	0
2014/15	384	304	79%	66	17%	14 (4%)	0

'Active application - an application is considered active from the date it is received until the date it is either formally withdrawn, not granted or the granted authorisation comes to an end.'

This year the number of applications that have yet to be signed off (353) have been included in the return to provide a more accurate picture of the number of active DoLS applications in Harrow. As a result, the data shows a higher number of active DoLS in this reporting period (1078) compared to last year (957). The proportion of cases that were given an outcome has not changed largely from last year.

	Total New Cases	**Granted**	**Granted (%)**	**Not Granted**	**Not Granted (%)**	**Withdrawn**	**Yet to be signed off**
2017/18	**561**(344)	**310**	90%	**32**	9%	**2 (1%)**	**217**
2016/17	385	326	85%	47	12%	12 (3%)	0
2015/16	725	591	82%	88	12%	46 (6%)	0
2014/15	384	304	79%	66	17%	14 (4%)	0

Similarly, applications that were received between 1st April 2017 and 31st March 2018 have increased from last year. Again, this is because of the large number of applications that are yet to be signed off. The proportion of DoLS applications that have been granted has increased by five per cent from last year.

2.3 HSAB Resources

As at 31st March 2018, the staffing of the dedicated Safeguarding Adults and DoLS Service located in the Council is as follows:-

1 Service Manager (Safeguarding Adults and DoLS)

1 DoLS Officer

1 Safeguarding Adults Co-ordinator

1 Team Manager

2 wte Safeguarding Adults Senior Practitioners

6 wte qualified Social Workers; and 1 wte care manager

2.5 wte Best Interest Assessors (DoLS work only)

Under the formal Section 75 agreement there are also a number of trained Safeguarding Adults Managers with a dedicated lead located in Central and North West London Mental Health NHS Foundation Trust (CNWL). The statistics for the CNWL Safeguarding Service are included in section 2.2 above.

In addition to staff, there are ongoing costs for the multi agency training programme; best practice forums; publicity (posters/fliers/wallet cards); awareness/briefing sessions; independent file audit and administrative support to the HSAB etc.

The costs of these services are primarily borne by the People Services Department within Harrow Council, with contributions totalling circa £21,000 p.a. from three of the four local NHS partner agencies (Harrow Clinical Commissioning Group; North West London Hospitals Trust; and the Royal National Orthopaedic Hospital Trust); the London Fire Service and Metropolitan Police.

Costs related to the time spent by partner agencies on HSAB activities e.g. attending meetings, facilitating staff release for training etc, are borne by the individual member organisations.

……..

SECTION 3 – MAKING A DIFFERENCE

(PROGRESS ON OBJECTIVES 2017/2018)

The next section of the report looks at what difference the work of the HSAB made last year by reviewing progress on the priorities agreed for 2017/2018, as set out in the annual report for 2016/2017. All HSAB member organisations have also progressed their own safeguarding priorities and reports on that work are also available through the relevant representative on the Board.

3.1 Training and Workforce Development

Multi-agency training remains a high priority for the HSAB. The existing programme is competency based, so that all staff know what is required for them to meet their safeguarding adults' responsibilities within the workplace. As a supplement to the formal training programme, the Safeguarding Adults and DoLS Service also ran briefing sessions across a range of agencies, offering most at the organisation's premises. The details are as follows:

Multi-agency training programme (commissioned)		**2017-18**	**+/- on 2016/17**
Harrow Council Internal		79	-30
Health		37	2
Statutory (other)		14	-4
Private		117	-24
Voluntary		68	-46
HSAB Board Development		100	32
SGA Team Development		28	-10
Partner Training: CNWL		9	9
	Total:	***452***	***-71***
SGA Team Briefing Sessions			
Children's Staff Inductions		20	20
HAD Staff & Volunteers		26	26
MIND Staff & Volunteers		49	49
Safe Place Scheme Briefing		8	8
Good Practice Workshops / Events / Conferences			
BIA Legal Update		25	25
Care Home Managers and Deputies		200	200
Children & Young People and Deprivation of Liberty		18	18
SAB/SCB Joint Annual Conference - Sexual Abuse within the Family		155	155
Scams, Fraud & Adults at Risk		88	88
Community & Service User Briefings			
Active Community Mondays		10	10
Milmans Day Centre Staff & Users		29	29
Rayners Lane Community Group		23	23
Roxeth Community Church		29	29
St John's Community Group		27	27
St Pauls Church Community Group		27	27
Tamil Seniors Group		35	35
Trinity Church Community Group		22	22
GP / Doctor / Medical Centres			
GP Surgeries (Clinical & Non-Clinical Staff)		20	20
Total Attending		***1263***	***-253***

Each year the multi-agency training programme and Best Practice Forums are developed from the evaluation and experience of the previous year's sessions. Last year there was a focus on mental capacity and unwise decision making.

Analysis of the attendance across the range of events suggests that the uptake of best practice forums and on-site "bespoke" sessions is greater than for the commissioned multi-agency formal training programme. Consequently, in 2019/2020 the HSAB has agreed to trial a shift in emphasis away from the formal classroom events and on to the one-off sessions which can be tailored to themes emerging from casework audits or SARs etc. A decision can then be taken about the best approach in future years.

HSAB member organisations' training activity

Each of the organisations represented on the HSAB also carry out their own training programmes to ensure that their staff are up to date. Examples include: at Harrow NHS Clinical Commissioning Group (CCG) where 72% of the staff required to complete mandatory safeguarding adults levels 1 – 3 did so last year; and at London North West Hospitals NHS Trust there was an 82% completion of level 1 training across all its various sites.

Safeguarding Adults Board Conference 2018

The HSAB and HSCB held their second joint conference in February 2018 with a focus on sexual abuse within the family.

Topics included: Exploring Good Practice and Not-So-Good Practice at different stages in a case of intra-familial Sexual Abuse: What does 'good' look like and how we can prevent and challenge practice that isn't? (Elly Hanson);
Sexual Abuse and People with Disabilities (Children & Adults) - Making the Invisible Visible (Harrow Mencap); Sexual Abuse and Older People - Exploring the Myths and Stereotypes and Responding to the 'Needs' of Older Victims (Dr Hannah Bows)

Evaluation was almost 100% positive from the 155 multi-agency staff that attended and there is a commitment from both Boards to continue collaborating on events in future years (see section 4). Some comments from the evaluation included:

"incorporated into my practice and I feel more 'alive' to the issues and possibilities with vulnerable adults and their families that I work with"

"had excellent contact with other professionals working in our contract area. It was lovely to get a cross-disciplinary perspective on child safety from the many academic speakers. Really valued speaker, Hannah Bows's contribution. I look forward to returning in the coming years. Just attending this event brought the issue more to the forefront for me to work into my prevention and education work as well as evaluate future safeguarding scenarios where SV within families plays a part"

"the knowledge gained from the workshops was extremely insightful"

"learning (from the Conference was) applied to support commissioning and contract performance of Services including monitoring of their multi-agency work with safeguarding partners"

Section 3.2	Progress on HSAB objectives
HSAB objective 1 (empowerment)	**Actions undertaken to progress objectives**
The HSAB ensures effective communication with its target audiences	*A range of methods are used throughout the year to provide information to all sections of the community with a focus on people/groups highlighted in the statistics (e.g. older people living in their own home and about the risks of financial abuse)*

The "little book of big scams" produced by the Metropolitan Police/Home Office was widely promoted by the Safeguarding Adults Coordinator.

The Council's Safeguarding Quality Assurance (SQA) Team newsletter in May 2017 covered a range of topics including: "Mental Capacity Act – the basics"; and "Fire Safety in care homes".

The Council's Safeguarding Adults Team used the free "Your Harrow" publication to raise awareness about scams.

The Council's Housing Department also highlighted scams and how to keep safe in its "Homing In" magazine.

The Mind in Harrow education course programme has promoted the Metropolitan Police 'Little Book of Big Scams' section about online scams and has provided a new user-friendly information sheet about safeguarding & Prevent to over 200 people with mental health needs to increase awareness.

Harrow Mencap's Forum for people with learning disabilities holds regular themed sessions on issues such as Speaking Out; Staying Safe; Hate Crime and Well-being to raise awareness, embed understanding and empower individuals. Representatives from the Safeguarding Team, Police and advocacy services have also attended. They have also held being safe on-line workshops with children, young people and young adult groups.

In CNWL, information in poster form about the nature of abuse/neglect was displayed appropriately in community mental health services premises. In 2017, a service user reference group was set up based in Harrow's community mental health teams. This group runs on co-production lines with a brief to promote the 'recovery' approach and ensure service user's views inform service developments in community services. The group has started to assist professionals to formulate changes that can be made to service provision in light of feedback received from Friends & Family Test. This has included:

- updating and improving the information given to new patients
- take forward actions to improve ratings on the Triangle of Care Audit's findings
- give advice about how clinicians can improve the provision of physical health monitoring when attending Bentley house.

CNWL Harrow routinely ask patients, their friends and family to complete a short questionnaire relating to the following 3 domains of patient experience:

- achieving what matters to them
- being treated with dignity and respect
- how involved they were in decisions about their care & treatment

At Royal National Orthopaedic Hospital (RNOH) a range of methods such as forums, magazines, patient leaflets, internet and intranet websites are used throughout the year to provide information and communicate with patients, staff, the community and stakeholders. RNOH publishes the Articulate Magazine every quarter for staff, patients, the community and stakeholders to get updates such as, pressure ulcer week and other patient safety information from the different departments. Hard copies are available in the directorates and soft copies can be accessed via the RNOH internet (public) and Intranet websites.

Central London Community Healthcare NHS Trust (CLCH) has developed a safeguarding leaflet which provides patients with information about safeguarding concerns. It explains what CLCH adult safeguarding services do, where they operate and how to get in touch with services should patients and or their family/carers require support. The public has access to information about CLCH services on the CLCH website.

The Harrow SAB's work is influenced by user feedback and priorities	*Demonstrable changes in practice are evident through file audit, user interviews and as presented by experts by experience at the HSAB Review Day and other relevant partner events*

Both the Council and CNWL's safeguarding services had an independent audit of casework last year – carried out by an external professional with significant experience in this field. Action plans have been created to address all the recommendations and progress will be tracked by the HSAB.

In the Council an independent/external social worker continues to interview users at the point of the enquiry being concluded. Her questions are focused around the Making Safeguarding Personal areas about involvement in the process and outcomes. All feedback is given to the Team so that practice continues to develop. Generally the feedback has been positive. The main challenge (also highlighted in audit reports) is the need to express the outcomes desired by users in a more measurable way.

The "deep dive" audit of repeat referrals presented to the HSAB last year found no cause for concern with only 2 cases where the referrer had needed to challenge the initial decision not to progress to the enquiry stage of the process. This area is being closely monitored by the Team Manager.

The Mind in Harrow User Involvement Project Coordinator facilitated 4 Mental Health Service User Representatives of the Harrow User Group (HUG) to present a user challenge at the Safeguarding Adults Board annual review/business planning day in June 2017 and have been working to ensure that the SAB responds with actions during 2018.

Harrow Mencap's Care Act advocacy service works with individuals on identifying the feedback they want from the safeguarding process and ensure this is heard by decision makers.

CLCH has good attendance on service user forums across several local authorities that they provide services to. CLCH Safeguarding Adults Team has also carried out service user feedback sessions. This provided invaluable information to help the Trust to understand how service users found their experience of safeguarding.

HSAB is reassured that there is access to justice for those who want it	*Annual statistics show an improvement in Police action/prosecutions*

There was a slight reduction in the numbers of cases where there was Police action or criminal prosecution last year compared to the progress made in 2016/2017, so this will remain a high priority for the HSAB in 2018/2019. However, although the statistics have reduced there are some excellent examples of strong partnership working between the Police and the Safeguarding Adults Teams e.g. the first cases of wilful neglect and coercive control being prosecuted in Harrow.

Mind in Harrow has contributed to a better coordinated multi-agency response to Appropriate Adult provision for people experiencing mental health problems who are arrested and detained through a Safeguarding Adults Board working group.

They have continued to raise the need for a solution to the lack of adequate Appropriate Adult response at SAB meetings.

Harrow Mencap work with individuals and groups on their rights including their right to report to the police. After a recent Hate crime forum one member saw another member being verbally abused in St Ann's Shopping Centre and as a result of the forum recognised this as hate crime and called the police. Harrow Mencap supports individuals to make statements to the police.

In CNWL Harrow ongoing liaison between mental health professionals and the Police occurs when a Safeguarding Concern triggers criminal investigation. Wards routinely offer patients opportunity to make statements to the Police where this is the case.

HSAB objective 2 **(prevention)**	**Actions undertaken to progress objectives**
The HSAB is reassured that partnership priorities are informed by local intelligence about risk and prevalence *The Harrow SAB ensures that community safety for vulnerable people is a high priority for action*	*Performance reports at quarterly Board meetings and the annual review day increasingly provide more detailed analysis e.g. by sector, user group and type of abuse – informing decisions about future campaigns* *Relevant campaigns take place each year (e.g. a focus on scams, door step crime, distraction burglary) and formal evaluation influences future activities* *Projects highlighted by users take place each year (e.g. working with schools to raise awareness of disability/mental health issues) and formal evaluation influences future activities* *More work is done with care providers and the general public about fire safety*

There have been a number of "deep dive" reports presented to the HSAB in 2017/2018 – including on domestic abuse and repeat referrals. These have enabled the Board to take decisions about future work e.g. asking Housing and the voluntary sector to raise awareness with staff about domestic abuse in a safeguarding context due to low numbers of referrals from those areas.

The quarterly HSAB newsletter has covered fire safety and a presentation was also given at the Board's quarterly meeting in December 2017 by the local Fire Service.

Information was given to local care providers at their forums about fire safety and followed up by the Council's Safeguarding Quality Assurance (SQA) Team in its newsletter.

As stated above, the "little book of big scams" has been widely promoted and well received.

In July 2017, Mind in Harrow contributed to the Harrow Safe Place Scheme by spending half a day speaking to several shop managers in central Harrow to encourage them to sign up to the scheme and providing their contact details to the Harrow Council safeguarding team.

Harrow Mencap has developed and delivered learning disability awareness training in schools. An evaluation of Harrow Mencap's Skill Up service led to the development of being safe on line workshops.

RNOH runs annual learning at work seminars for patients, stakeholders and staff. During the seminar, all the different directorates such as safeguarding children and adults have stands to provide information such as 10 Golden Rules to prevent scammers, Independent mental Capacity Advocates, hoarding, staff contacts, advice and support.

The Harrow SAB ensures that dignity is a high priority for local care providers	*Providers e.g. care homes and/or domiciliary agencies are supported with relevant information/training*

The Council's Safeguarding Quality Assurance (SQA) Team ran a programme of training sessions for care providers in 2017/2018 including: SCIE sessions on dementia/challenging behaviour (80 staff) and Tissue Viability Nurse led sessions about pressure care (90 people).

The Council's Safeguarding Adults multi-agency training programme was advertised in the SQA Team's newsletter in September 2017 – resulting in excellent take up with 185 private and voluntary sector staff attending relevant courses.

96% of service users self-reported feeling safe and supported while using Mind in Harrow's services during 2016-17, which was an improvement on 93% in the previous year.

All Harrow Mencap care staff undertake training in providing care with dignity. All new staff undertake the Care Certificate. All services have quality standards that include dignity in care and are subjected to internal audit and CQC inspections.

CNWL routinely ask patients, their friends and family for direct feedback via a short questionnaire in regard to whether they have been treated with Dignity and Respect.

Harrow CCG along with the Local Authority provided a structured education day for nursing homes that was very well received and attended and is in the process of trying to provide on-going education for the homes and their staff. This will cover issues around safeguarding and advanced care planning to support the staff and residents in the nursing homes.

Harrow CCG has also worked with the local authority and the local Primary Care Educational Team in link to the Royal College of General practice to help implement the red bag scheme for nursing homes and Full moon care planning to incorporate anticipatory care plans and Advanced wishes.

CLCH has strong values that uphold the principle of dignity and equality. The CLCH Quality Strategy (2017-2020) has clear campaigns to ensure the delivery of care to patients is safe, caring and compassionate and that staff treat all service users with dignity and respect in keeping with the organisational culture. The Quality campaigns are:

- **a positive patient experience** – changing behaviour and care to enhance the experience of our patients and service users
- **preventing harm** – reducing unwarranted variations in care and increasing diligence in practice
- **smart effective care** – ensuring patients and service users receive the best evidence-based care, every time
- **modelling the way** – providing world class models of care, education and professional practice
- **here, happy, healthy and heard** – recruiting and retaining an outstanding clinical workforce
- **value added care** – using enhanced tools and technologies to manage resources well

Some local care providers marked Dignity Day 2018 by running events for their residents.

The HSAB is reassured that staff are well informed about the new safeguarding areas e.g. modern slavery, domestic abuse and sexual exploitation (including forced marriage)	*Staff are supported with relevant information/training and numbers of concerns in these areas increase*

There were more concerns about modern slavery and domestic abuse in 2017/2018 than the previous year suggesting wider knowledge amongst professionals, however numbers are still relatively low so this will remain an area of focus for the HSAB in 2018/2019.

Four staff from Mind in Harrow attended the joint safeguarding adults and children's conference in February 2018, attending workshops on different aspects of abuse and neglect, increasing their awareness and understanding about child sexual abuse. Mind in Harrow ran a workshop session at the conference about the mental health impact on adults of childhood sexual abuse.

All Harrow Mencap staff attend basic awareness and refresher training. Safeguarding is a standing item on every team agenda and this ensures that staff are kept up to date. Staff are able to confidently identify and report safeguarding concerns. All front-line staff as a policy undergo safeguarding training before completion of their probation (within the first three months of joining). Safeguarding champions have been appointed in the various teams including support workers. Safer recruitment training has been implemented and all line managers participated and apply the principle in staff selection.

CNWL's Liaison Psychiatry Team is accessing training provided by the Hestia Modern Slavery Team, to ensure they are up to date on knowing what are the indicators that someone presenting in crisis at an Emergency Dept or admitted to hospital may have symptoms or injuries that are due to abuse or neglect as manifestations of domestic abuse, sexual exploitation/trafficking and/or modern slavery. CNWL undertook its first enquiry into an allegation of Modern Slavery in year. This led to establishing links with the key commissioned service for supporting survivors of Modern Slavery, Hestia. CNWL Harrow held a number of awareness training sessions for mental health professionals in regard to FGM.

CNWL rewrote its policy on Domestic Abuse in the financial year. Two training briefings led by IDVAs (domestic violence advocates) employed by Hestia given to staff in community mental health team in year. This outlined when and how to completed a Domestic Abuse checklist and refer to MARAC or for other domestic abuse support services.

RNOH's mandatory and staff induction safeguarding adults training informs staff about modern slavery, domestic abuse and sexual exploitation, forced marriage, mate crime and honour based violence. The safeguarding team have a safeguarding advice phone number and bleep which staff contact for ad-hoc advice. RNOH has leaflets and posters in the clinical areas and the internet and intranet to inform staff about the new safeguarding areas. The Named Nurse for safeguarding Adults also informs staff during ad-hoc supervision, training, safeguarding adults board meeting and Senior Nurses forum about current safeguarding headlines and pitfalls discussed during HSAB meetings to enhance safeguarding practice.

The Designated Nurse for Safeguarding Adults at the Harrow Clinical Commissioning Group (CCG) is a member of the London Region Modern Slavery Network. The group aims to inform the London Region Safeguarding steering group and to make certain that NHSE carries out its responsibilities in relation to modern slavery. Information from the group is also shared with the Harrow Modern Slavery Working Group within the local authority. Assurance is sought from the provider organisations commissioned by the CCG in ensuring modern slavery and domestic abuse are embedded in their policies as well as training. Harrow CCG together with their NHS provider organisations have a modern slavery statement on their website.

The Designated Nurse (Adults) at the CCG, together with NHSE Regional Prevent Coordinator – London as well as a Lead from the General Medical Council delivered a Workshop to Raise Awareness of Prevent (WRAP) training to 30 Harrow General Practitioners. The GMC Lead went through confidentiality and sharing of information in great detail with the General Practitioners and the feedback after the training was really positive.

At LNWHUT domestic abuse awareness has been firmly incorporated into the training provided to Trust staff with two Independent Domestic Violence Advocates (IDVA's) employed in the Emergency Rooms at both Ealing and Northwick Park Hospitals.

The IDVAs provide support to patients attending the hospital and act as a crucial resource for front line staff delivering care. Secondly, Modern Slavery and Human Trafficking abuse was also incorporated in Adult safeguarding Training. Staff across Children's and Adult Safeguarding Service have completed the London ADASS & NHS England "Train the Trainer: Human Trafficking and Modern Slavery Multiagency Awareness Raising Training.

CLCH give staff more up to date and in-depth knowledge around issues such as Modern Slavery, Female Genital Mutilation (FGM), and domestic abuse.

The training package is in line with the Intercollegiate Framework and as a result of increased awareness, staff are making more enquiries with the safeguarding team about concerns in relation to Modern Slavery. The safeguarding team works closely with the sexual health teams around complex safeguarding issues in relation to their service users. The Safeguarding Advisor has participated in the 'My Marriage My Choice' research project run by the University of Nottingham and RESPOND. The safeguarding team have membership with the Standing Together against domestic violence Domestic Violence Co-ordinators Network. CLCH also has a specialist advisor for domestic violence.

HSAB objective 3 **(proportionality)**	**Actions undertaken to progress objectives**
Staff are confident in balancing risks with user empowerment	*More work takes place to increase staff confidence (in all agencies) in completing mental capacity assessments and using DoLS*
The Harrow SAB is reassured that Making Safeguarding Personal (MSP) is well embedded in practice	*HSAB is provided with quantitative data (in addition to the existing qualitative information) about MSP outcomes (based on the return to NHS Digital)*

A range of training sessions took place in 2017/2018 including "young people and deprivation of liberty". The Council's Safeguarding Team had some "bespoke" sessions picking up the findings from file audits which included further work on undertaking mental capacity assessments with people deemed to be taking unwise decisions and facing significant risk.

The 200 care home and domiciliary agency managers attending the Provider Forums last year received sessions on the Mental Capacity Act (MCA), including unwise decision making.

Harrow Mencap are compliant in this area. The Mental Capacity Act (MCA) and DOLS is covered with staff during the induction process. The Independent Mental Capacity Advocate ensures that that people without someone to support them are heard and that the least restrictive option is used.

At present, 84% of CLCH Harrow staff are compliant with MCA Level 2 training and 76% of CLCH Harrow staff are compliant with MCA Level 3 training.

Training was implemented on sex and relationship management for CLCH managers and front line staff to enable them to gain knowledge and confidence in handling difficult clients' sex and relationship issues.

At CNWL Harrow, training in regard to assessment of mental capacity is available for staff. They will use this skill routinely in their contact with people struggling with mental health difficulties, not only in the context of a Safeguarding Concern/Enquiry. CNWL has appropriate and proportionate checks and balances in place to ensure that the application for a DoLs is considered, applied for and the situation monitored if there is a delay in authorisation being granted.

At RNOH, most staff are confident in identifying patients/users who fulfil the criteria for MCA/DoLS by balancing risks with user empowerment. However some staff show lack of confidence in completing mental capacity assessments and using DoLS. The Named Nurse for Safeguarding Adults has oversight of patients/users who require MCA/DoLS and provides adequate support for staff to complete their mental capacity assessments and DoLS applications.

The Council's casework audits during 2017/2018 were structured around the MSP areas and feedback included a need for further refinement of how user outcomes were being described and recorded. It was not possible last year to provide the voluntary return to NHS Digital as the Mosaic system could not generate the required information.

The Harrow SAB is reassured that DoLS processes are an integral part of its prevention arrangements	*DOLS arrangements are effective and least restrictive options are identified in all cases. The new Liberty Protection Safeguards as proposed by the Law Commission will be addressed when required by statute*

Deprivation of Liberty Safeguards (DOLS) practice is now well embedded in Harrow and the statistics for last year are shown at section 2 above.

Work around completion of mental capacity assessments and using DoLS is monitored at the various Clinical Quality Groups as well as during Safeguarding and Quality assurance visits conducted by the CCG's Designated Nurse Safeguarding Adults and Assistant Directors for Quality.

At the time of writing this report there are 6 cases currently being heard at the Court of Protection with the Official Solicitor representing the person who has asked for the DoLS authorisation to be challenged on their behalf. The Court will decide whether its in their best interest to continue living at the care home or whether a less restrictive option is available.

The HSAB has an effective Quality Assurance framework in place which includes relevant approaches to overseeing effective practice	*Relevant "mystery shopping" exercises or equivalents check that front door services recognise possible abuse and know how to advise/deal with concerns effectively* *A minimum of 40 externally audited and 30 internally audited cases will be completed each year; and independent user interviews will take place – with a focus on ensuring that a person centred approach to practice (including use of advocates) identified the outcomes desired by users* *A "deep dive" into repeat referrals will be completed and reported to the HSAB with any required recommendations*

The HSAB has had a quality assurance framework in place for 10 years.

As referred to above, the Mind in Harrow User Involvement Project Coordinator facilitated 4 Mental Health Service User Representatives of the Harrow User Group (HUG) to present a user challenge at the Safeguarding Adults Board annual review/business planning day in June 2017 and has been working to ensure that SAB responds with actions during 2018. Improvements requested by User Representatives were systemic issues raised by mental health service users from their direct personal experiences of Harrow safeguarding processes.

Mind in Harrow has not been able to identify a "mystery shopping" exercise format which is a meaningful test of front door responses and which is not also presenting an actual live safeguarding concern being raised. Therefore the previous annual mystery shopping exercise with Mental Health Service User Representatives of the Harrow User Group (HUG) is currently on hold.

Harrow Mencap has internal quality standards including those for safeguarding which are audited annually. There are regular opportunities for people who use the service to feedback through satisfaction surveys and through telephone monitoring. Random spot checks by managers/supervisors are carried out regularly.

At CNWL Harrow, an audit of enquiries from January to March 2017 was undertaken in November 2017 by an independent safeguarding Social Worker. Findings and recommendations formulated an action plan that is being implemented to enhance and improve learning of staff.

The Council commissioned Professor Jill Manthorpe to carry out a "critical friend" review of how it quality assures its safeguarding arrangements. The report concluded:

"I was asked to consider whether the citizens of Harrow and their elected representatives can be assured of the quality of adult safeguarding in Harrow. From the perspective of the local authority, which is still the lead agency for this area of work, there are good grounds for confidence that London Borough of Harrow is not complacent about the challenges of adult safeguarding, that it has responded to the changes deriving from the Care Act 2014, and that it has several systems to check and interrogate its professionals' activities. While we have learned that there is no risk-free safeguarding, in my view the quality assurance systems for adult safeguarding in Harrow are well-designed, consistently applied and effective".

Recommendations are being addressed – for example that overseas workers recruited into Children's Services be provided with safeguarding adults training which has resulted in this topic being a standing item on all induction programmes in that Department.

Both the Council and CNWL's safeguarding services had an independent audit of casework last year – carried out by an external professional with significant experience in this field. Action plans have been created to address all the recommendations and progress will be tracked by the HSAB.

In the Council an independent/external social worker continues to interview users at the point of the enquiry being concluded. Her questions are focused around the Making Safeguarding Personal areas about involvement in the process and outcomes.

All feedback is given to the Team so that practice continues to develop. Generally the feedback has been positive. The main challenge (also highlighted in audit reports) is the need to express the outcomes desired by users in a more measurable way.

The "deep dive" audit of repeat referrals presented to the HSAB last year found no cause for concern with only 2 cases where the referrer had needed to challenge the initial decision not to progress to the enquiry stage of the process. This area is being closely monitored by the Team Manager.

CLCH adult safeguarding team have under taken the 3rd annual Mental Capacity audit in Q4. The aim of the audit was to establish whether staff are considering a patient's mental capacity by demonstrating understating of the 5 principles and adherence to the MCA Code of Practice and are documenting this clearly. Recommendations include more training on consent and the need for a mental capacity tool in the district nurses assessment.

The HSAB has accessible and effective information available to those who might need it	*A full range of updated information for practitioners, service providers and people who may need to use safeguarding services is available in a range of accessible formats*

In the Council, all the information about "how to report a concern" and "what happens after you report a concern" in easy to read formats (primarily for users) and the associated documents aimed at professionals was updated and uploaded on to the website.

Mind in Harrow's Care Act Information & Advice Service (SWiSH) has provided information about the safeguarding process to 22 people with mental health needs or their carers - who have reported to us that they may be at risk of abuse or neglect to ensure timely and appropriate referral.

Harrow Mencap provides easy read information on what is abuse and how to report concerns. There is also the whistleblowing policy in place.

The lead for safeguarding within CNWL Harrow visited Harrow Mencap Operational meeting to clarify what the actual working procedure for raising a Safeguarding Concern for someone at risk or experience abuse/neglect, who also has mental health difficulties is. Briefing provided. Flowcharts detailing how to raise safeguarding concerns for those of different ages and residents of Harrow and neighbouring Boroughs revised and disseminated, replacing previous ones from Dec 2015.

HSAB objective 4 (protection)	Actions undertaken to progress objectives
The HSAB and HSCB work collaboratively ensuring a "whole family" approach to safeguarding work	*Joint projects (e.g. annual conferences, training events, community outreach, work with schools) will be explored wherever possible - to optimise both resources and outcomes* *A joint approach to domestic abuse with a focus on areas highlighted by statistical analysis e.g. Housing and the voluntary sector*

There is a standing quarterly business meeting between the officer supporting the HSAB and the officer supporting the HSCB where information is shared and opportunities for collaboration are explored. The joint HSAB HSCB annual conference is a good example of a positive outcome.

In response to requests for independent advocacy support from adults with mental health needs, who as parents are under the care of secondary care mental health services and subject to child protection process, Mind in Harrow raised the need for funded advocacy provision not currently available. As a result, from 2017 the Council has agreed to spot purchase independent advocacy for these service users for whom two referrals have been made to-date.

Harrow Mencap has delivered learning disability awareness training in schools and led a workshop at the HSAB/HSCB joint conference on Sexual abuse and disability. Harrow Mencap collaborated with the British Institute of Learning Disability and FPA – the Sexual Health Charity - to facilitate two key programs.

RNOH safeguarding Adults and Children Team work collaboratively with its Psychology/mental Health Team and responsible Local Authorities Domestic Abuse Services and Safeguarding Adults teams to ensure a "whole family" approach to safeguarding work.

As stated above, the Council's Safeguarding Adults Service now provides awareness training at all Children's Services induction days for new workers.

In October 2017 CLCH held its first annual safeguarding conference. This was a day-long conference covering topics on Child Sexual Exploitation (CSE), Mental Capacity Act 2005, Modern Day Slavery and Making Safeguarding Personal. The conference was a success in terms of numbers of attendees and feedback and it will be held again in 2018/2019.

Learning is embedded in practice and leads to continuous service improvement	

In 2017-18 Mind in Harrow's national body (Mind) conducted an independent panel audit of Mind in Harrow's quality against 150 indicators including safeguarding adults and children. The panel held separate feedback sessions with service users, staff, volunteers and trustees, from which we were commended for the high quality of our practices. We have agreed a continuous quality improvement plan with our Board for 2018-19 for example improving the visibility of information about how service users can complain.

Harrow Mencap has an open and critical approach to reviewing alerts and referrals embracing reflective learning to improve practice. Cases are reviewed by the Senior Manager and at the bi-monthly Safeguarding Leads meetings, issues are followed up including looking at areas of weakness, barriers and ensuring these are addressed and communicated. A central Safeguarding Log is held. Safeguarding is a standing item on every team agenda and at every levels of the organisation including at board level.

A new training package was implemented by CLCH in October 2017**.** Level 2 training can now be accessed as an e-learning course and Level 3 training is a classroom based session. A 90 minute classroom session for Safeguarding Adults has been implemented which has replaced the previous 60 minute session. This is being delivered in a workshop style so to help facilitate discussion amongst attendees whilst they work with case studies (typically scenarios from published SARS) to further embed what is being taught.

HSAB objective 5 (partnership)	**Actions undertaken to progress objectives**
The HSAB is effective as a partnership	*HSAB considers undertaking the NHS England/ADASS Risk Audit Tool in 2017/2018* *HSAB annual review and business planning day incorporates challenge from "experts by experience" and an independent facilitator*

All statutory member agencies and many non-statutory agencies represented on the HSAB completed the risk audit tool in 2017/2018. Each agency reported its findings to the HSAB highlighting the areas for action in 2018/2019.

Safeguarding Adults Risk Assessment Tool was revised by CNWL's Service Lead for Safeguarding in late March 2017. Provided to Local Authority who host/administrate the Harrow Safeguarding Adults Board (HSAB) in July. 22 Criteria, which as of March were RAG rated as being Red – 1, Amber - 6, Green – 15. Red item has been addressed. Further work on moving rating of Amber Criteria to 'Green' required.

RNOH has a risk register with RAG ratings similar to the NHS England/ADASS Risk Audit Tool.

NHS CCG Harrow along with providers submitted to the HSAB the annual safeguarding adults at risk audit tool. This enables the CCG as well as providers to submit evidence of compliance within their own policy standards. It was identified that some staff members due to change in roles may need to have the Disclosure Barred Service (DBS) check done.

As part of the Learning Disabilities and Mortality Programme (LeDeR), a steering group has been established in Harrow and is tasked to oversee all completed reviews of deaths and to identify where actions need to be taken and what key messages are emerging.

Experts by Experience attended the HSAB annual review and business planning day in 2017 and challenged the Board in specific areas under the headings “ordinary lives are safer lives” and “how to keep people with mental health problems safe”. This will be followed up by Mind in Harrow and Harrow Mencap at the annual event in 2018 to check what progress has been made by Board members.

HSAB objective 6 **(accountability)**	**Actions undertaken to progress objectives**
Elected Councillors, Executives and Committee members in all relevant partner agencies are aware of their personal and organisational responsibilities	*Briefings are provided on a quarterly basis by HSAB members to their organisations at a senior level sufficient to ensure ownership of the issues and leadership to agree any changes required*
The general public is aware of safeguarding issues and the work of the HSAB *Relevant staff are aware of safeguarding issues and the work of the HSAB*	*The HSAB Annual Report for 2017/2018 is published in an “easy to read” format and posted on all partner websites* *The HSAB Annual Report for 2017/2018 is published in “Executive summary” and “staff headlines” formats and posted on all partner websites* *A full range of updated information for practitioners, service providers and people who may need to use safeguarding services is available in a range of accessible formats*
Learning is embedded in practice and leads to continuous service improvement	*The multi-agency safeguarding adults training programme is updated annually based on formal evaluation; and learning from audits, user feedback and SARs* *The multi-agency safeguarding adults training programme is re-tendered at the end of the current contract*

In the Council, the DASS and Service Manager meet quarterly with the Chief Executive, Leader, Portfolio Holder and Corporate Director to provide an update on safeguarding adults’ work. These sessions provide both information for the senior recipients, but also challenge back to the Department e.g. to carry out further awareness raising sessions with local Banks.

Mind in Harrow’s Board of Trustees reviews its safeguarding adults and children’s policies each year and is required to undertake as mandatory safeguarding training during their induction period as new Trustees. The Chief Executive updates the Board annually about Mind in Harrow’s contribution to the HSAB work plans.

At Harrow Mencap, safeguarding is a standing item on the board agenda and there is a trustee with responsibility for safeguarding. Two managers are also serving as board members/governors in schools within the locality to advance safeguarding issues.

CNWL Harrow's care quality meeting, attended by Senior Clinicians and Management continues to receive a report on a quarterly basis outlining activity, service developments etc.

At CLCH, information is fed back via the monthly senior managers meeting and the monthly safeguarding Named Nurse and Safeguarding Advisors meeting.

The annual report for 2016/17 was made available in "Executive summary", "easy to read" and "staff key messages" versions, widely circulated and available on partner websites. All HSAB member organisations confirmed that the report had been presented at their Executive Board or equivalent and there was a presentation to the Council's Scrutiny committee on 3rd July 2017.

See section 3.1 above in relation to training and development in 2017/18.

Section 4: Action plan priorities – 2018/2019 (year 2 from the Strategic Plan 2017 - 2020)

The Board's priorities are developed from analysis of the statistics presented at quarterly meetings; feedback from users; learning from research, audits; and case reviews. They are organised around the four Care Act statutory requirements and six principles.

Principle One: **Empowerment**	**Description:** *Presumption of person led decisions and informed consent*	**Outcome for users at risk:** *"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens"* *"I have access to justice if I want it"*
Objectives and how they will be achieved and measured	**Actions**	**Timescale**
The HSAB ensures effective communication with its target audiences Impact and effectiveness are evaluated and influence changes to future campaigns	A range of methods are used throughout the year to provide information to all sections of the community with a focus on people/groups highlighted in the statistics (e.g. older people living in their own home and about the risks of financial abuse)	End March 2019
The Harrow SAB's work is influenced by user feedback and priorities User feedback at annual review events reports progress on agreed projects	Further attempts are made with Head Teachers to engage with young people and adults at risk – in relation to disability awareness and social inclusion	End March 2019

Principle Two: **Prevention**	**Description:** *There is a culture that doesn't tolerate abuse, dignity/respect are promoted and it is better to take action before harm occurs* *Communities have a part to play in preventing, detecting and reporting neglect and abuse*	**Outcome for users at risk:** *"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help"*
Objectives and how they will be achieved and measured	**Actions**	**Timescale**
The HSAB is reassured that partnership priorities are informed by local intelligence about risk and prevalence Performance reports at quarterly Board meetings and the annual review day provide more detailed analysis – informing decisions about future campaigns	Change the reporting to the HSAB such that routine performance information (e.g. repeat referrals, Police action, modern slavery) is highlighted on an exception basis only Focus to be on more "deep dive" statistical reports in areas of interest/concern to the HSAB e.g. sexual abuse by location	End September 2018 End March 2019
The Harrow SAB ensures that community safety for adults with care/support needs is a high priority for action Numbers of home fire safety checks increase from the 2017/18 out-turn position	Relevant campaigns take place each year (e.g. a focus on scams, door step crime, distraction burglary) and formal evaluation influences future activities Work continues with care providers and the general public about fire safety	End March 2019 End March 2019
The Harrow SAB ensures that dignity is a high priority for local care providers More Providers in Harrow improve their CQC rating each year	Provider concerns are monitored at Board meetings and commissioners oversee quality assurance Providers are supported with relevant information/training	End March 2019 End March 2019

The Board supports elected Councillors and others in similar roles to recognise abuse and report their concerns	Provide annual training/refresher events for elected Councillors and those in similar roles across partner agencies	End March 2019
Principle Three: **Proportionality**	**Description:** *Proportionate, person centred and least intrusive response appropriate to the risk presented (best practice)*	**Outcome for users at risk:** *"I am sure that the professionals will work for my best interests, as I see them and will only get involved as much as needed and I understand the role of everyone involved in my life"* *"I had the support of an advocate if I needed one"*
Objectives and how they will be achieved and measured	**Actions**	**Timescale**
The HSAB has an effective Quality Assurance framework in place which includes relevant approaches to overseeing effective practice Demonstrable changes in practice are evident through file audit, user interviews and as presented by experts by experience at the HSAB Review Day and other relevant partner events	A minimum of 40 externally audited and 30 internally audited cases will be completed each year; and independent user interviews will take place – with a focus on ensuring that a person centred approach to practice (including use of advocates) identified the outcomes desired by users Audit reports will be taken to the HSAB with any required actions and proposed recommendations	End March 2019 Bi-annual

Staff are confident in balancing risks with user empowerment	Audit findings, user feedback, SAR actions and Risk Panel learning to be fed into the Multi-agency Training Programme and Best Practice Forums Work continues to take place to increase staff confidence (in all agencies) in completing mental capacity assessments and using DoLS/Court of Protection	End March 2019 End March 2019
Learning is embedded in practice and leads to continuous service improvement The multi-agency safeguarding adults training programme is updated annually based on formal evaluation; and learning from audits, user feedback and SARs	The approach to multi-agency safeguarding adults training is changed in 2019/2020 – to run more best practice forums and bespoke events (on emerging topics) - with recommendations for future programmes reported to HSAB in March 2020	April 2019 End of March 2020
The Harrow SAB is reassured that Making Safeguarding Personal (MSP) is well embedded in practice There is a reduction in “not known” and “other” outcomes recorded at the end of safeguarding enquiries Return is made to NHS Digital)	Work is completed to investigate if the Jade (or its replacement) and Mosaic systems can record the more diverse variety of outcomes likely to be achieved for adults at risk through MSP HSAB is provided with quantitative data (in addition to the existing qualitative information) about MSP outcomes (based on the return to NHS Digital)	End December 2018 End March 2019

Principle Four: **Protection**	**Description:** *Support and representation for those in greatest need*	**Outcome for users at risk:** *"I get help and support to report abuse"* *"I get help to take part in the safeguarding process to the extent to which I want and to which I am able"*
Objectives and how they will be achieved and measured	**Actions**	**Timescale**
The HSAB is reassured that adults at risk are empowered to raise concerns from any setting (including in-patient units and care homes) and that advocacy is being sought and provided to those that seek it as part of the safeguarding adults enquiry process	Projects are implemented as highlighted by users e.g. task and finish group or learning review for CNWL in-patient services; and presentation by Public Health about their role with reducing social isolation	End March 2019

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Principle Five: **Partnership**	**Description:** *Effective partnership working ensures a "whole family" approach leading to the best possible outcomes for users* *Effective partnership working ensures an effectively coordinated approach leading to the best possible outcomes for users*	**Outcome for users at risk:** *"I know staff treat any personal and sensitive information in confidence, only share what is helpful and necessary"* *"I'm confident professionals will work together to get the best result for me"*
Objectives and how they will be achieved and measured	**Actions**	**Timescale**
The HSAB is effective as a partnership	HSAB monitors the actions resulting for each agency represented on the Board from the NHS England/ADASS Risk Audit completed in 2017/2018	End March 2019
The HSAB and HSCB work collaboratively ensuring a "whole family" approach to safeguarding work Joint projects (e.g. annual conferences, training events, community outreach, work with schools) will be explored wherever possible - to optimise both resources and outcomes	A third joint HSCB HSAB conference will be held in 2018/2019 with a focus on "trafficking and modern day slavery"	End March 2019

Principle Six: **Accountability**	**Description:** *There is accountability and transparency in delivering safeguarding. The Board meets its statutory requirements as set out in the Care Act 2014.* *Learning from local experiences and national policy/research improves the safeguarding arrangements and user outcomes*	**Outcome for users at risk:** *"I understand the role of everyone involved in my life"*
Objectives and how they will be achieved and measured	**Actions**	**Timescale**
The statutory HSAB Annual Report is produced	HSAB receives the Annual Report within 3 months of the end of each financial year	End June 2019 (for the 2018/19 report)
The HSAB Annual Report is presented to all relevant accountable bodies	Presentation is made to Scrutiny Committee to include progress against the previous year's action plan and objectives for the coming year All partner agencies present the Annual Report to their Board (or equivalent) within 3 months of the agreement by the HSAB Presentation is made to the Harrow Health and Wellbeing Board with particular reference to progress on agreed joint priorities and recommendations for the coming year	First available Scrutiny meeting after the Annual Report is discussed and agreed at the HSAB (& no later than the end of October 2019 for the 2018/19 report) First Board meeting after the Annual Report is agreed (and no later than the end of October 2019 for the 2018/19 report) First Health and Wellbeing Board meeting after the Annual Report is agreed (and no later than the end of October 2019 for the 2018/19 report)

Elected Councillors, Executives and Committee members in HSAB agencies are aware of their personal and organisational responsibilities	Briefings are provided on a quarterly basis by HSAB members to their organisations at a senior level sufficient to ensure ownership of the issues and leadership to agree any changes required	End March 2019
The general public is aware of safeguarding issues and the work of the HSAB Relevant staff are aware of safeguarding issues and the work of the HSAB	The HSAB Annual Report for 2018/19 is published in an “easy to read” format and posted on all partner websites The HSAB Annual Report for 2018/19 is published in “Executive summary” and “staff headlines” formats and posted on all partner websites	End July 2019 (for the 2018/19 report) End July 2019 (for the 2018/19 report)

Appendix 1

Statistic	2015/2016	2016/2017	2017/2018	*National figure (2016/17)
Concerns	1690	1662 (2% decrease)	1467 (11% decrease)	6% increase
Concerns taken forward as enquiries	40%	39%	43%	41%
Repeat referrals (enquiries)	19%	31%	17%	28%
Completed referrals (enquiries)	100%	95%	99%	100%
Concerns from non white ethnic backgrounds	51%	48%	51%	16%
Where abuse took place	Client's own home (61%) Care Homes (20%)	Client's own home (63%) Care Homes (14%)	Client's own home (57%) Care Homes (19%)	Client's own home (44%) Care Homes (36%)
User group	Older people (46%) Physical Disability (40%) Mental Health (31%) Learning Disability (13%)	Older people (48%) Physical Disability (38%) Mental Health (33%) Learning Disability (12%)	Older people (48%) Physical Disability (34%) Mental Health (31%) Learning Disability (13%)	Older people (63%) Physical Disability (42%) Mental Health (12%) Learning Disability (13%)

Type of abuse	Physical (23%) Neglect (21%) Emotional (20%) Financial (17%) Not recorded this year	Physical (19%) Neglect (21%) Emotional (20%) Financial (22%) Self neglect (14 cases) Domestic abuse (75 cases)	Physical (19%) Neglect (22%) Emotional (20%) Financial (19%) Self neglect (28 cases) Domestic abuse (86 cases)	Physical (24%) Neglect (35%) Emotional (14%) Financial (16%) Self neglect - (not available) Domestic abuse - (not available)
Person alleged to have caused harm (highest incidence first)	Family including Partner (35%) Social care staff (22%)	Family including Partner (35%) Social care staff (19%) Stranger (4%)	Family including Partner (41%) Social care staff (21%) Stranger (5%)	Not available
Outcomes for adult at risk	Increased monitoring (13%) Community Care Services (13%) Court of Protection application (1%) Advocacy (2%) MARAC referral (5%)	Increased monitoring (13%) Community Care Services (17%) Court of Protection application (1%) Advocacy (3%) MARAC referral (1%)	Increased monitoring (12%) Community Care Services (20%) Court of Protection application (1%) Advocacy (2%) MARAC referral (1%)	Not available
Prosecutions/Police action as an outcome for PACH	12%	16%	14%	Not available

*The 2016/17 data is the most recent national information available for comparison

Appendix 2

HSAB Membership (as at 31st March 2018)

HSAB Member	Organisation
Florence Acquah	London North West Healthcare NHS Trust (hospital services)
Kate Aston	Central London Community Health Care NHS Trust
Christine-Asare-Bosompem	Harrow NHS Clinical Commissioning Group
Cllr Simon Brown	Elected Councillor (Portfolio Holder), Harrow Council
Claire Clarke	Metropolitan Police – Harrow (Vice Chair)
Karen Connell	Harrow Council Housing Department
Julie-Anne Dowie	Royal National Orthopaedic Hospital NHS Trust
Vanessa Duke	Westminster Drug Project
Andrew Faulkner	Brent and Harrow Trading Standards
Mark Gillham	Mind in Harrow
Lawrence Gould	Harrow (NHS) CCG – GP/clinical representative
Sarah Green	NHS England - London Region
Garry Griffiths	Harrow NHS Clinical Commissioning Group
Paul Hewitt	People Services, Harrow Council
Sherin Hart	Private sector care home provider representative
Chris Miles	London Ambulance Service
Mina Kakaiya	Healthwatch Harrow
Jules Lloyd	London Fire Service
Nigel Long	Harrow Association of Disability
Coral McGookin	Harrow Safeguarding Children's Board (HSCB)
Avani Modasia	Age UK Harrow

Cllr Chris Mote	Elected Councillor (shadow portfolio holder), Harrow Council
Tanya Paxton	CNWL Mental Health NHS Foundation Trust
Deven Pillay	Harrow Mencap
Visva Sathasivam	Adult Social Care, Harrow Council (Chair from December 2017)
Officers supporting the work of the HSAB	
Sue Spurlock	Safeguarding Adults and DoLS Services – Harrow Council
Seamus Doherty	Safeguarding Adults Co-ordinator - Harrow Council

Appendix 3 **Harrow Safeguarding Adults Board** **Attendance Record 2017/2018**

Organisation	June 2017	September 2017	December 2017	March 2018	Total attended
HSAB Chair	√	√	√	√	4
Brent and Harrow Trading Standards	√	X	√	√	3
Harrow Council - Housing Department	√	√	X	X	2
London Ambulance Service	X	X	X	√	1
London Fire Service	X	X	√	√	2
Westminster Drug Project	X	X	√	√	2
Harrow Council - Adult Social Services	√	√	X	X	2
Harrow Council - elected portfolio holder	√	X	√	√	3
Harrow Council - shadow portfolio holder	X	X	X	√	1
Harrow Council – People Services/Children's Services	√	√	√	X	3
Mind in Harrow	√	√	√	√	4
NHS Harrow (Harrow CCG)	√	√	√	√	4
CLCH NHS Trust (Harrow Provider Organisation)	√	√	√	√	4

London North West Healthcare University Hospitals Trust	√	√	√	√	4
Harrow CCG – clinician	√	√	√	√	4
Local Safeguarding Children Board (HSCB)	√	√	√	√	4
Royal National Orthopaedic Hospital	√	√	√	√	4
Metropolitan Police – Harrow (Vice Chair)	√	√	√	√	4
Age UK Harrow	X	X	X	X	0
Harrow Mencap	√	√	√	√	4
CNWL MH Trust	√	X	√	√	3
Harrow Association of Disabled People	X	X	X	X	0
Private sector provider representative (elected June 2013)	√	√	√	X	3
Public Health	X	X	X	X	0
Department of Work and Pensions	X	X	X	X	0
In attendance					
Care Quality Commission (CQC)	X	X	X	X	0
Healthwatch Harrow (other Board members e.g. from Harrow Mencap and Mind in Harrow are also Healthwatch Harrow members)	X	X	X	X	0

Further information/contact details

For further information about this report or any aspect of safeguarding vulnerable adults at risk of harm in Harrow, the website is:

www.harrow.gov.uk/safeguardingadults

If you would like information or advice (including how to access the multi-agency training programme) the Safeguarding Adults Service can be contacted on the telephone number below or via e-mail at:

safeguarding.adults@harrow.gov.uk

If you are concerned about an adult with care/support needs that might be at risk of harm and want to make a referral for an older person or an adult with a disability, this can be done through Access Harrow on: 020 8901 2680
(ahadultsservices@harrow.gov.uk)

If you are concerned about an adult with care/support needs that might be at risk of harm and want to make a referral for a younger person with mental health difficulties, this can be done through 0800 023 4650 (CNWL single point of access).

(cnw-tr.mentalhealthsafeguardingharrow@nhs.net)

Any enquiries about the Deprivation of Liberty Safeguards (DoLS) including requests for authorisations can be e-mailed to: DOLS@harrow.gov.uk

DoLS requests can also be sent to the safe haven fax: 020 8416 8269.

The address for written correspondence (to either Access Harrow or the Safeguarding Adults and DoLS Service) is:

Civic Centre
PO Box 7,
Station Road,
Harrow, Middx. HA1 2UH

Putting patients at the HEART of everything we do

London North West University Healthcare NHS Trust

LNWUHT HARROW OSC BRIEFING			
Date of Meeting: 15th October 18			☐ **Overview and Scrutiny Committee**
Item No. **Board Report No.**	**Xx** **Xx**	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☐ Information	
Subject: CQC inspection: outcomes and next steps			
Director Responsible: Barbara Beal, Interim Chief Nurse		**Author:** Ted Nyatanga, CQC Quality Assurance Lead Barbara Beal Interim Chief Nurse	

Summary:

The Care Quality Commission (CQC) undertook an announced inspection of London North West University Healthcare NHS Trust for 3 days from 5 to 7 June 2018. Scheduled inspections took place across 4 of our sites: Northwick Park, Ealing, Community Inpatients-Willesden and Clayponds and Community Dental.

The CQC also undertook a 'Well-Led' specific inspection of the entire service from the 3 to 6 July 2018 through tours and scheduled interviews with senior managers, service leads and the Executive team.

An unannounced inspection took place between 8 to18 July 2018.

As part of the inspection, the CQC spoke to patients, visitors, carers and staff (in the hospitals, in focus groups and formal interviews) to gain a view of London North West University Healthcare NHS Trust' 8 core services; Surgery, Critical care, Maternity/Gynaecology, Services for Children and Young People, Medical care, Urgent & Emergency Care, Community and Community Dental Services.

The CQC methodology seeks to rate each of these in relation to five domains:

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

In the period prior to the inspection, the Trust provided large amounts of documentation to the CQC via a process called the Provider Information Return (PIR). This was followed by further Data Requests (DR) during and after inspection. A total of approximately 700 DRs were received and responded to. The CQC use this information to provide focus during their inspection and triangulate their inspection results. All responses were provided within the required deadline and the inspection ran smoothly as a result of the robust preparation and engagement with staff at all levels and the CQC commented very positively on how the Trust hosted them.

The CQC issued six potential breaches of legal requirements that the Trust had to put right in advance of the reports publication. The report was published at the end of August and the overall Trust rating remained unchanged as 'Requires Improvement' from the previous CQC 2015 inspection-see summary table below;

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Northwick Park Hospital	Requires improvement → ← Aug 2018	Requires improvement ↓ Aug 2018	Good → ← Aug 2018	Requires improvement → ← Aug 2018	Requires improvement ↓ Aug 2018	Requires improvement ↓ Aug 2018
Ealing Hospital	Inadequate ↓ Aug 2018	Requires improvement → ← Aug 2018	Good → ← Aug 2018	Requires improvement → ← Aug 2018	Requires improvement → ← Aug 2018	Requires improvement → ← Aug 2018
Central Middlesex Hospital	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014	Requires improvement Aug 2014	Good Aug 2014
Community Services	Good ↑ Aug 2018	Requires improvement → ← Aug 2018	Good → ← Aug 2018	Good ↑ Aug 2018	Good ↑ Aug 2018	Good ↑ Aug 2018
Overall trust	Requires improvement → ← Aug 2018	Requires improvement → ← Aug 2018	Good → ← Aug 2018	Requires improvement → ← Aug 2018	Requires improvement ↓ Aug 2018	Requires improvement ↓ Aug 2018

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

Main highlights from the report include overall ratings as follows;

- Good for the 'Caring' domain with outstanding practice identified within Surgery and Community Inpatients services
- Good for Inpatient Community Service
- Inadequate for the 'Safe' domain at the Ealing site
- Inadequate for the Maternity service at Northwick Park site

Within the final report the CQC identified 39 'MUST DOs and 72 SHOULD DOs that the Trust needs to address to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality. The Trust has developed an action plan in response to all of these that was submitted to the CQC by the 30th

September 2018 deadline.

The CQC will check that the Trust takes the necessary action to improve its services. They will continue to monitor the safety and quality of services through the continuing relationship with the Trust and their regular inspections.

Active and Next Steps include;

- Trust Action Plan submitted to the CQC on 30th September 2018
- Key stakeholders invited to the CQC Quality Summit on 6th November 18
- The Executive Team to meet monthly for oversight of progress against the CQC action plan and with the development and implementation of the Quality Improvement Programme. The new Quality and Safety Committee will provide Board oversight.
- 8 of the 31 Maternity actions to address bleep system risk and security issues, among other identified concerns, have been completed with ongoing compliance monitoring
- 3 Care Quality Improvement work streams have been established and are progressing robust actions to mitigate medicines management, documentation and clinical risk assessment practice issues supported by the NHSI intensive support team and the Chief Pharmacist
- Treatment of children in the Ealing ED has been stopped; this has been communicated and reiterated to all staff. The Paediatric care environment including transfers is being improved and monitored
- Mandatory training compliance is being accelerated through various initiatives including more face to face and online sessions and introduction of a new system by HR
- NHSI have agreed to identify and support the allocation of a 0.5 WTE Quality Improvement Director (shared with Hillingdon Hospitals NHSFT) .
- £200k has been allocated by NHSI to support the Trust with the CQC improvement programme to include: 3.0 WTE band 8a posts to support and implement sustainable changes within the divisions and across the Trust as well as the NHSI Medical Engagement Survey; these were approved at the Executive Committee on 19th September 18
- An NHSI approved Maternity Advisor has commenced support to the Trust maternity services work stream
- The Trust has appointed the first cohort of 20 quality improvement leads that is ongoing in line with the Transformation programme
- A Quality Summit is scheduled for 6th November 2018, supported by NHSI
- Ambition to move from Requires Improvement to Outstanding in next 2 years

Recommendations

The Oversight and Scrutiny Committee is asked to note the CQC inspection outcomes, action being undertaken and next steps

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London North West Healthcare NHS Trust

Inspection report

Watford Road
Harrow
Middlesex
HA1 3UJ
Tel: 02088643232
www.lnwh.nhs.uk

Date of inspection visit: 5th June to 7th June 2018
Date of publication: 31/08/2018

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

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

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

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

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

Summary of findings

Background to the trust

London North West University Healthcare NHS Trust is one of the largest integrated care trusts in the country, bringing together hospitals and community services across Brent, Ealing and Harrow.

London North West University Healthcare operates hospital services from three main hospital sites:

- Northwick Park Hospital
- Ealing Hospital
- Central Middlesex hospital.

The trust was established on 1 October 2014 from the merger of Northwick Park Hospital, Ealing Hospital NHS Trust and Central Middlesex Hospital. The trust employs more than 9,000 clinical and support staff and serves a diverse population of approximately one million people.

The trust also provides a range of community services in the London Boroughs of Brent, Ealing and Harrow and has three community hospitals; Clayponds Rehabilitation Hospital, Meadow House Hospital and Willesden Community Rehabilitation Hospital.

In December 2017 the trust was officially named a university teaching hospital.

The trust was last inspected in 2015 and was rating requires improvement.

The trust has 1,260 beds including:

- 66 children's beds and neonatal care cots
- 68 maternity beds
- 33 critical care beds
- 1,037 acute adult beds
- 90 community hospital beds.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement

➔ ➔

What this trust does

The trust runs services at Northwick Park Hospital, Ealing Hospital and Central Middlesex Hospital.

The trust provides, urgent and emergency care, medical care, surgery, critical care, maternity, gynaecology, children's and young people services, end of life care and outpatient services. The trust also provides a range of community services including: diabetic eye screening, district nursing, falls services, family dental, musculoskeletal specialist and physiotherapy services and many more.

We inspected Northwick Park Hospital, Ealing Hospital, Community In-Patient services and Community Dental services.

Summary of findings

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspection based on everything we know about services, including whether they appear to be getting better or worse.

Between 5-7 June 2018, we inspected six core services at Northwick Park Hospital and four core services at Ealing hospital. We also inspected two community services.

We inspected urgent and emergency care because we rated the service at both sites as required improvement during our last inspection.

We inspected medical care because we rated the service at both sites as required improvement during our last inspection.

We inspected surgery because we rated the service at both sites as required improvement during our last inspection.

We inspected children and young people's services because we rated the service at both sites as required improvement during our last inspection.

We inspected maternity because we rated the service as required improvement during our last inspection however, we only inspected at Northwick Park Hospital as the maternity unit has now closed at Ealing hospital.

We inspected critical care because we rated the service as required improvement during our last inspection. However, we only inspected critical care at Northwick Park as the information we reviewed about the service indicated an improvement in the safety and quality of this service at Ealing Hospital.

We did not inspect outpatients, gynaecology, diagnostic imaging and end of life at both sites because the information we reviewed about these services indicated no change in the safety and quality of these services.

We inspected community dental services because we rated the services as required improvement during our last inspection.

We inspected community inpatient services because we rated the services as required improvement during our last inspection.

We did not inspect other community services because the information we reviewed about these services indicated no change in the safety and quality of these services.

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

Summary of findings

- We rated safe, effective, caring and well-led as requires improvement, and caring as good. We rated three of the trust's services as requires improvement, one service as good and two of the services as inadequate. In rating the trust, we took into account the current ratings of the other services not inspected this time.
- We rated well-led at the trust as requires improvement.

Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

- Mandatory training completion rates for nursing and medical staff were not meeting the trust target. There had been insufficient improvement since the previous inspection.
- Processes and systems were not reliably in place to protect children from abuse and harm. Children on the child protection register were not always identified, and arrangements for vulnerable patients between 16 and 18 years were not robust.
- Nutrition and hydration assessments were not always completed. We found gaps in feeding charts and the frequency of patient assessment reviews.
- The trust did not always provide a smooth and timely transition for patients moving between children and adult services. The trust did not have a transition policy and staff felt that guidelines required clarity.
- The last inspection report included a requirement for the trust to ensure Control of Substances Hazardous to Health (COSHH) assessments were up to date and maintained. We found COSHH assessments on medical wards which were significantly out of date, and ward managers unaware if the assessment had been completed or not.
- Incidents of mixed sex accommodation breaches in critical care were only recently recorded and investigated appropriately.
- The service continued to face significant issues with ambulance turnaround which led to high numbers of black breaches.
- There was a lack of supervision for lower grade doctors and out of hours medical support to the wards in community services.

Are services effective?

Our rating of effective stayed the same. We rated it as requires improvement because:

- The unplanned readmission to critical care within 48 hours of discharge was worse when compared with results for similar units and nationally.
- From March 2017 to February 2018, the trust's unplanned re-attendance rate to accident and emergency within seven days was worse than the national standard of 5% and also consistently worse than the England average.
- The trust did not comply with the principles outlined in the National Enquiry into Patient Outcome and Death (NCEPOD) classifications around access to emergency theatres.
- The National Hip Fracture Database audit showed the crude proportion of patients having surgery on the day of or day after an admission was in the worst of 25% of hospitals. The crude overall hospital length of stay fell in the worst 25% of hospitals
- The trust completion rate for appraisals was 62%, significantly below the trust target of 85%.

Summary of findings

- Staff understanding of patients need for Mental Capacity Act (MCA) and deprivation of liberty(DoL) assessments was variable. Some staff were not able to demonstrate awareness of when MCA and DoL's assessments would be necessary.

Are services caring?

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

- Results from the Friends and Family Test responses exceeded the trust standard and 100% of respondents reported they would recommend the service in critical care.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients and relatives and could signpost them to services within the organisation as well as external organisations for additional support.
- Patients and relatives told us staff were respectful and helpful and gave them regular updates.
- Observations of care showed staff maintained patients' privacy and dignity on most wards visited, and patients and their families were involved in their care.

Are services responsive?

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

- Bed occupancy between March 2017 and February 2018 averaged 80% which was not in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) recommendation of 70% critical care occupancy.
- Similar to what we found at the previous inspection, there were issues with patient flow in the urgent and emergency care department. Patients were waiting for long periods of time in the department and experienced delays accessing beds within the hospital.
- There were six patients at the emergency department who waited more than 12 hours from decision to admit until being admitted
- Referral to treatment times were not being met for some surgical specialities such as general surgery, colorectal surgery, oral surgery and ear nose and throat.
- The trust performance for cancelled operations was worse than the England average.
- Patient records we viewed for people living with dementia did not have the care pathway document completed, or only partially completed. This meant that the individual needs of patients were not being adequately recorded, which may have impacted on the availability of enhanced care.
- Medical wards at Ealing Hospital followed the trust "+1" escalation policy. This stated that at times of high activity, an additional patient could be cared for in the corridor of the ward. Most staff we spoke with stated that this policy did not provide patients with sufficient privacy or dignity. We reached the same conclusion. Patients were spending long periods in corridors before being provided with a bed in a bay or being discharged.

Are services well-led?

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

- Patient flow out of critical care was still a significant issue and the unit was an outlier for delayed discharges.
- Some staff raised concerns about the culture in the urgent and emergency care department. Some staff felt they were not listened to by the trust, especially when it came to decisions about service development.

Summary of findings

- Staff and managers were clear about the challenges their department faced. They explain the risks to the department and the plans to deal with them. However, the risk register did not contain all risks we found within a department.
- There were no joint governance meetings between the emergency department and the urgent care centre. This meant learning from serious incidents was not shared with the urgent care centre.
- Staff we spoke on medical wards stated there were not opportunities for engagement at Ealing Hospital, and they did not feel represented or consulted on the future direction of the hospital. Staff from medical wards consistently stated that the lack of engagement was impacting on morale for staff.
- Staff we spoke with across medical wards were unsure of the future development plans or the vision for the division at Ealing Hospital. Staff stated that the communication from the trust regarding future plans was somewhat unclear, and that this created some anxiety for the staff. Staff we spoke wit also stated they did not feel they had been consulted on the direction of the clinical strategy.
- Medical staff stated that patient pathways and the delivery of services were redesigned without consulting the medical workforce, which meant that changes did not always include local knowledge on what worked well and what could be improved.

Outstanding practice

We found areas of outstanding practice in Surgery and Community Inpatients detailed below.

Areas for improvement

We found areas for improvement including six breaches of legal requirements that the trust must put right. We found 74 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

Action we have taken

We issued requirement notices to the trust and took five enforcement actions. Our action related to breaches of zero legal requirements at a trust-wide level and six in a number of core services and locations.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

In surgery:

- Staff demonstrated a focus on improvement and dedication to adapting national pilot schemes and new strategies to their patient group.
- The specialist palliative care team undertaking developments to facilitate more supervision and support for surgical inpatients.
- A matron had supported surgical staff in the implementation of a " make a difference" project to improve quality standards and opportunities for joint working.

Summary of findings

In community inpatient services:

- Relatives and patients all told us that staff were caring and compassionate. They gave us clear examples of how staff had made patient admissions a good experience which included for those who were more vulnerable or who had extra need.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve

We told the trust that it must take action to bring services into line with legal requirements. These actions are related to six core services: Medical care, urgent and emergency care, maternity, children and young people services, surgery and critical care.

Medical Care at Ealing hospital- Warning notice

The trust must:

- Assess the risks to the health of service users on medical wards.
- Have staff following policies and procedures about managing medicines on medical wards.
- Have the sufficient numbers of suitably qualified, competent skilled and experienced persons deployed within the medical wards.

Urgent and Emergency Care at Ealing hospital – Warning notice

The trust must:

- Ensure that in the accident and emergency (A&E) department at Ealing hospital the trust must have the arrangements in terms of the environment and the equipment to treat children.
- Support the provision of safe care and treatment and must demonstrate that there is proper and safe management of paediatric medicines.

Maternity at Northwick Park Hospital – Warning Notice

The trust must:

- Ensure robust systems are in place to ensure that the correct staff are bleeped on an ongoing basis including a system of regular checks of the bleep system to ensure that the correct staff are bleeped at all times.
- Ensure robust systems are in place to ensure unauthorised persons cannot gain access to theatres via use of the staff/ theatre lift.
- Ensure the doors to the delivery suite from theatres are by secure access only.
- Ensure the main doors to the maternity unit cannot be forced open at any time of the day or night.

Urgent and Emergency Care at Ealing hospital –Notice of Decision

The trust must:

Summary of findings

- Stop treating children (individual aged under 16) in the Ealing Urgent and Emergency Department which is an emergency department for adults only except for clinically stabilising the child before transferring to an appropriate facility.
- Develop a clear policy on the management of children who present to or are brought to the Ealing Urgent and Emergency Department stating in clear terms the extent to which staff in the Urgent and Emergency Department stating can be involved in the management and care of children.
- Place visible signs in the Ealing Urgent and Emergency Department informing members of the public that the department is not a paediatric emergency department.
- Following actions taken by the trust and the submission of an ongoing action plan, CQC notified the trust that it had discontinued the notice of decision subject to the improvements set out by the trust's actions and action plans being sustained.

Urgent and Emergency care- at Northwick Park Hospital Requirement notice

The trust must:

- Review the processes, implementation and recording of observations of mental health patients in the ED department.
- Ensure that there are effective systems in place for learning from incidents.

Critical Care at Northwick Park Hospital- Warning Notice

The trust must:

- Have beds appropriately located within critical care to perform emergency lifesaving care and treatment.
- Have sufficient handwashing facilities to mitigate the risk of cross-contamination.

Children and Young People Services at Ealing hospital – Requirement Notice

The trust must:

- Improve compliance with mandatory training especially for medical staff.
- Provide nursing staff with training in the recognition and management of children with sepsis.
- Provide nursing staff with clinical and safeguarding supervision.
- Ensure a protocol is easily accessible and available for staff to follow if a child or young person became unwell on the unit.
- Have clear oversight of young people admitted to adult wards.
- Improve staffing levels including staffing establishment on the children's outpatients and day care unit.
- Ensure there are effective systems in place for sharing the learning from incidents.

Children and Young People Services at Northwick Park Hospital– Requirement Notice

The trust must:

- Ensure robust safeguarding systems and procedures are put in to place to ensure children are protected from harm and abuse.
- Ensure that nutrition and hydration assessments are routinely carried out and consistently reviewed.

Surgery at Northwick Park Hospital – Requirement Notice

Summary of findings

The trust must:

- Improve medicines management to include regular, documented checks of the temperature in storage areas including refrigerators.
- Address the low levels of compliance with mandatory training amongst the medical team. We identified this as an area for the trust to improve in our last inspection in October 2015.
- Ensure sufficient nursing staff have up to date training in basic and immediate life support.
- Implement a system to ensure all equipment is regularly inspected, safe and fit for purpose.

Surgery at Ealing Hospital – Requirement Notice

The trust must:

- Ensure patients are cared for in areas that are appropriate, meet all of their needs and have sufficient space to accommodate the potential number of people using the service at any one time.
- Ensure proper and safe management of medicines. This includes avoiding practices that compromise safe medicines management including the use of pre-prepared medication in theatres.
- Ensure there are sufficient staffing levels on orthopaedic wards.
- Work to improve access and flow within surgical services.
- Work to improve mandatory training completion rates for medical staff.
- Ensure staff on the Ealing site are engaged in planning and delivery of services.
- Improve theatre utilisation and efficiencies related to start and finish times.
- Improve referral to treatment times in surgery.

Action the service SHOULD take to improve

Community Dental

The trust should:

- The provider should ensure that learning from incidents is always shared with the wider team.
- The provider should ensure there is oversight of risk assessment action plans and all outstanding actions are completed.
- The provider should ensure mandatory training is completed in line with the trust mandatory requirements.
- The provider should ensure the service had effective systems for identifying risks, planning to eliminate or reduce them.
- The provider should ensure radiography audits were completed annually to improve the quality of the service.

Community Inpatients

The trust should:

- The trust should review how it measures nursing staffing need so that it adequately reflects the needs of a rehabilitation service.
- The trust should review its practice of reliance on a small number of bank staff and ensure that where healthcare assistants are filling nursing shifts, that this is properly risk assessed.

Summary of findings

- The trust should review medical cover to account for gaps in supervision of junior grade doctors and out of hours support to the community hospitals.
- The trust should adequately ensure that risks posed by lack of security presence at Willesden are minimised/ lack of security presence at Willesden is resolved to keep patients safe.
- The trust should ensure the supervision for lower grade doctors.
- The trust should consider increasing the skill mix of nurses at the Willesden Community Rehabilitation Hospital in order to support patients when there was no medical cover on the wards, where there were no nurses trained as advanced nurse practitioners or trained to carry out physical assessments.

Urgent and emergency Care at Northwick Park Hospital

The trust should:

- Ensure that patient records detail the care and treatment provided including a record of drink and food provided.
- Make sure the mental health assessment room provides a therapeutic environment.
- Improve compliance with mandatory training especially for medical staff.
- Improve on pain assessments and timely administration of pain relieving medicines in paediatric emergency department.
- Improve the recording of pain scores in the paediatric emergency department
- Improve appraisal rates.
- The trust should continue to work towards improving flow and capacity within the ED to improve performance against the national target.
- Reduce the number of black breaches
- The trust should continue to proactively manage recruitment and retention of nursing staff.
- The trust should consider how to improve IT systems across the department to enable easier sharing of information.
- Ensure the departments risk register incorporates all risks to the department and each risk is monitored robustly.

Urgent and emergency Care at Ealing Hospital

The trust should:

- Ensure there is a clear policy on the location of emergency paediatric medicines in the emergency department.
- Ensure staff meet the trust targets for mandatory training.
- Ensure that the service meets the target for staff appraisals.
- Ensure that medical staff complete mental capacity training.
- Review the arrangements for patients being admitted into the chest pain area in the clinical decision unit (CDU).
- Address nursing and medical vacancies in the emergency department.

Medicine at Northwick Park Hospital

The trust should:

- The service should ensure safe levels of staff to ensure the provision of safe care and treatment.

Summary of findings

- The service should ensure there is consistency in relation to document completion across the wards in particular fluid balance charts and malnutrition universal screening tool assessments.
- The service should ensure medical staff understand their roles and responsibilities in relation to the Mental Capacity Act 2005.
- The service should ensure mandatory training for medical and nursing staff meets the trust target of 85%.
- The service should take action to reduce patients' length of stay on medical wards.

Medicine at Ealing Hospital

The trust should:

- Ensure that medical patients admitted on other wards receive a consultant ward round in line with the trust's policies for medical patients.
- Ensure that high dependency patients are provided with appropriate staff in line with national guidance.
- Ensure that staff are adequately trained in the appropriate completion of the patient records booklet.
- Ensure that clinical governance processes are applied consistently across wards.
- Ensure that staff receive an appraisal at least annually.
- Ensure that medical consultants are provided with clear job plans which are reviewed annually.

Surgery at Northwick Park Hospital

The trust should:

- Review how staff access policies and procedures to reduce the likelihood of serious incidents resulting from a failure to follow accepted practice.
- Ensure healthcare assistants have access to incident-reporting systems and understand how to use them.
- Ensure infection control practices are consistent and protect patients and staff from the risks associated with bacteria growth and cross-infection.
- Ensure trust doctors who carry the on-call bleep out of hours are fully aware of the need to respond to calls from staff working in the Sainsbury Wing.
- Ensure staff understand fire safety procedures, including the purpose and use of fire doors.
- Ensure patients and those close to them remain up to date with care and treatment plans from the medical team.

Surgery at Ealing Hospital

The trust should:

- Work to improve hand hygiene compliance on Ward 7 North.

Critical Care at Northwick Park Hospital

The trust should:

- Work to improve compliance with mandatory training for medical and nursing staff.
- Work to improve patient flow through the critical care unit.
- Work to reduce mixed sex breaches on the ward.

- Improve trust wide sharing and learning from incidents.

Children and young person's services at Northwick Park Hospital

The trust should:

- Ensure that nursing and medical staff are compliant with mandatory training.
- Update the safeguarding training strategy and ensure that delivery of children's safeguarding level 3 is compliant with the intercollegiate document.
- Ensure that all risk assessments including pain scores and pressure ulcer assessments are completed and reviewed in a timely manner.
- Take steps to improve communication throughout the children's and young people's service, particularly feedback regarding incidents and lessons learnt.
- Review the provision for children with a learning disability and mental health concern to ensure that timely support is available at all times.
- Ensure robust processes are in place for the transition between children and adult services.

Children and young person's services at Ealing Hospital

The trust should:

- Ensure all clinical guidelines and policies for children's services have been reviewed in line with trust timescales.
- Ensure that adult outpatient areas where children were seen are child friendly.
- Improve facilities for adolescents on the children's outpatients and day care unit.
- Provide information leaflets in languages other than English.
- Increase health promotion information available on the children's outpatients and day care unit for was limited.
- Increase engagement with the public in improvement and design of the service.
- Ensure management dedicate adequate time to the Ealing Hospital site.

Maternity at Northwick Park Hospital

The trust should:

- Ensure staff mandatory training meets trust standards.
- Ensure there is an abduction policy for maternity and ensure staff know how to respond in the event of an infant or child abduction or suspected abduction.
- Ensure there are tail gating notices on all wards and departments.
- Ensure the floor covering in the antenatal clinic toilet does not pose an infection control risk.
- Ensure there is an alert system in place for community midwifery staff working off-site.
- Ensure emergency guidelines clarify which teams will attend emergency calls and disseminate this to staff.
- Ensure all patient complaints are investigated and closed within the trust's published policy timescales.
- Ensure there is increase visibility of divisional and local leads.
- Take steps to improve working relationships within the service.

Summary of findings

- Prioritise cultural improvements within the maternity team.
- Ensure identified risks on the risk register are actioned in a timely way or at the earliest opportunity.

Is this organisation well-led?

- Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.
- We rated the organisation for well led as requires improvement.
- Shaping a Heathier Future, the wider plan for health and social services in North West London, which affected the services at this trust, was the subject of ongoing debate with the local population. Progress on this had slowed and the pace of strategic change at the trust had also slowed as a result. The trust leadership appeared either slow or unable to bring about a reconfiguration of services outside of that inertia. We observed that this had led to a paralysis in organisational change and lack of ambitious vision.
- At our last inspection we noted considerable uncertainty and anxiety particularly at Ealing over the future of the hospital. This anxiety was also evident at our latest inspection. Communication with staff at Ealing was not considered desirable by the trust leadership until firm plans had been enacted to move services there. This was prolonging that uncertainty.
- Fit and proper persons checks were in place. However, we found some deficiencies in the trust's processes and records.
- All board meetings started with a patient story presented. However, there was little evidence of regular visits by senior executives and board members to ward and other areas of the trust.
- There was currently no development programme for the board or executive team, having been unsuccessful in the past. We saw no advanced plans to reinstate a board development programme.
- We did not see evidence that staff, patients and carers had plenty of opportunity to contribute to discussions about the strategy, especially where there were plans to change services.
- 54% of staff at the trust would recommend the trust as a place to work against a national average of 59%. The level of satisfaction towards the organisation and management interest in health and wellbeing was slightly below the national average.
- Relationships between the recognised trade unions and the trust did not appear to be harmonious or based on trust.
- There was no description of how the trust would handle staff concerns in its annual report and accounts. The Freedom to Speak up Guardian was not mentioned in that document. Staff in different parts of the trust told us that they had little opportunity to directly raise concerns with senior managers within the trust.

Summary of findings

- Staff did not always feel able to raise concerns without fear of retribution. In the latest NHS Staff survey (2017) for the trust, staff confidence and security in reporting unsafe clinical practice was below (worse than) the national average. Similarly, staff confidence in the fairness and effectiveness of procedures for reporting errors, near misses and incidents was below (worse than) the national average.
- Duty of candour processes were generally followed. However, the quality of duty of candour letters was generally poor. There was no evidence of engagement with patient relatives or carers during the investigation process or in determining terms of reference for the investigation.
- Staff did not always feel that equality and diversity were promoted in their day to day work and when looking at opportunities for career progression. The percentage of staff experiencing discrimination at work was higher than the national average. The percentage of staff believing that the organisation provided equal opportunities for career progression was lower than the national average.
- There were two BAME networks operating – one at Ealing and one at Northwick Park. Information from focus groups which CQC held indicated that BAME staff felt that they were discouraged from advancing beyond a certain level in the trust to senior posts even though many were highly qualified in comparison to their non-BAME colleagues. There were claims of higher levels of disciplinary action being taken against BAME staff.
- At our inspection three years previously, we detected a lack of team working and spirit particularly between staff at Ealing and Northwick Park and we detected little improvement during our latest inspection, particularly in the light of ongoing uncertainty felt by Ealing staff about the future of the hospital. Staff at Ealing still complained about non-communication from the trust leadership about the future of the hospital and there remained a perception of lack of support from the board and executive team as a result.
- The present board and governance committee structure had been introduced just prior to the last inspection in 2015. However, it was now too complex and cumbersome to facilitate efficient conduct of governance and board assurance. There were too many committees with seeming overlap of responsibility.
- We were not assured that the trust's governance framework was sufficiently detailed to address the need to meet people's mental health needs and those with learning difficulties. We did not see one cohesive document in relation to this but many piecemeal documents and references.
- Staff had access to the risk register either at a team or division level and could effectively escalate concerns as needed. In most cases staff concerns matched those on the risk register. However, in our core service inspections we came across several examples of concerns that were not on local risk registers at all locations. We were not assured that robust arrangements were in place in all departments for identifying, recording and managing risks, issues and mitigating actions.
- There was a process in place to escalate to board and committee oversight. The trust board had sight of the most significant risks. However, mitigating actions were not always clear and what the board received did not provide assurance in relations to controls in place to manage or mitigate risks and gaps in control and assurance.
- In reviewing trust documentation on risk, serious incident investigation, review of deaths, duty of candour, complaints etc. and action plans arising, we noted a common theme of a lack of certification of completion of improvement or sign from actions identified.
- The Board Assurance Framework (BAF) as an assurance framework needed further development. The document we saw was more of a summary document than a full BAF but the trust confirmed that this document was its full BAF. As a purported full document, it was not fit for purpose. Executive leads were not always identified and the board committee ownership was not always clear between for example the integrated governance committee and the audit committee. It was not always clear what were the sources of assurance for the relevant risks and there were gaps in assurance.

Summary of findings

- Despite the board receiving information at its board meetings on assurance we were concerned to note that the board were not sighted on the issues we found in core service inspection in relation to ED at Northwick Park, Medical wards at Northwick Park, maternity at Northwick Park, Surgery at both Northwick Park and Ealing and services for children and young people at Ealing.
- Despite concerns being escalated to the board, for example in relation to security in the maternity department and lack of space around beds and bed spacing in critical care there had been a lack of action to mitigate those risks.
- The internal auditors had provided an in-depth review checking that policies, reporting and quality checks were in place. Despite this we found a number of policies to be out of date or subject to review. There were five audit recommendations to improve data quality on RTT- two of which were high priority.
- We were not assured that staff were always fully involved in decision making about changes to the trust services. A theme emerged during our inspections that some staff members perceived that they had not been fully consulted about some changes including those to the ED and in critical care at Northwick Park. In addition, we were told by different groups of staff on different occasions that they did not feel listened to. We observed a contrast in the perception of issues between senior management and front-line staff, particularly at the Ealing site.
- We noted that there was no formally identified executive/board level lead for children contained in trust documentation that we saw, nor in information on its website nor in its annual report and accounts document.
- Although, patients, staff and carers could meet with members of the trust's leadership team and governors to give feedback at public board meetings, we were told that, other than this, the executive and non-executive board were not highly visible.
- However, we did find areas of good practice:
- The trust board had the appropriate range of skills, knowledge and experience to perform its role.
- The trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience.
- Staff members below board level had access to a course in effective leadership led by a local university.
- The trust had a lead for child and adolescent mental health, learning disability and autism.
- The trust board and senior leadership team displayed integrity on an ongoing basis.
- The trust board had a clear vision and set of values with quality and sustainability as the top priorities.
- The trust worked with staff, patients and local stakeholders to develop a new set of values and behaviours based on HEART – honesty, equality, accountability, respect and teamwork.
- There was a strategy for achieving the priorities and developing good quality, sustainable care across all sectors of the trust – acute and community**.**
- Staff motivation at work was higher than the national average.
- Managers addressed poor staff performance where needed. The Director of HR said that a number of staff were currently being performance managed. However, we did not see a clear and completed Performance Management and Accountability Framework which would ensure consistency of approach.
- The trust also had control over sickness absence resulting in much lower than average sickness absence levels by comparison with other NHS trusts.
- The trust Freedom to Speak up Guardian had been in post for about a year and reported directly to the chief executive. A second part time guardian, senior in the trust had recently been appointed to assist. They felt that they were supported by the trust though it was a challenge to work across three acute sites and in community services.

Summary of findings

- Most staff had the opportunity to discuss their learning and career development needs at appraisal. The trust stated in its latest annual report (2016/17) that 85% of its staff had received an appraisal. However, the percentage of staff reporting that they had received an appraisal in the previous twelve months was lower than the national average as reported in the 2017 NHS Staff Survey. The percentage of staff praising the quality of their appraisal was higher than the national average.
- Staff had access to support for their own physical and emotional health needs through occupational health.
- Papers for board meetings and other committees were of a reasonable standard and contained appropriate information. However, papers were sometimes late due to the complexity and number of committees in the governance structure.
- There were plans in place for emergencies. For example, adverse weather, a flu outbreak or a disruption to business continuity. The trust stated that it had in place plans that were compliant with the requirements of the NHS England Emergency Planning Resilience and Response Framework 2015 and associated guidance.
- The trust was actively participating in clinical research studies. Research and education made up approximately five per cent of the trust's income.

Use of resources

NHSi conducted a use of resources inspection at the same time as the CQC inspection. NHSi rated use of resources as requires improvement because the trust did not consistently manage its resources to allow it to meet its financial obligations on a sustainable basis and to deliver high quality care.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↓ Aug 2018	Requires improvement ➔➔ Aug 2018	Good ➔➔ Aug 2018	Requires improvement ➔➔ Aug 2018	Requires improvement ➔➔ Aug 2018	Requires improvement ➔➔ Aug 2018

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Northwick Park Hospital	Requires improvement →← Aug 2018	Requires improvement ↓ Aug 2018	Good →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement ↓ Aug 2018	Requires improvement ↓ Aug 2018
Ealing Hospital	Inadequate ↓ Aug 2018	Requires improvement →← Aug 2018	Good →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018
Central Middlesex Hospital	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014	Requires improvement Aug 2014	Good Aug 2014
Community Services	Good ↑ Aug 2018	Requires improvement →← Aug 2018	Good →← Aug 2018	Good ↑ Aug 2018	Good ↑ Aug 2018	Good ↑ Aug 2018
Overall trust	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018	Good →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement ↓ Aug 2018	Requires improvement ↓ Aug 2018

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

Ratings for Northwick Park Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement → ← Aug 2018	Requires improvement ↑ Aug 2018	Good → ← Aug 2018	Requires improvement → ← Aug 2018	Requires improvement → ← Aug 2018	Requires improvement → ← Aug 2018
Medical care (including older people's care)	Requires improvement → ← Aug 2018	Requires improvement ↑ Aug 2018	Good → ← Aug 2018	Requires improvement → ← Aug 2018	Requires improvement → ← Aug 2018	Requires improvement → ← Aug 2018
Surgery	Requires improvement ↑ Aug 2018	Good → ← Aug 2018	Good → ← Aug 2018	Good ↑ Aug 2018	Requires improvement → ← Aug	Requires improvement ↑ Aug 2018
Critical care	Requires improvement → ← Jun 2018	Good ↑ Jun 2018	Good → ← Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018
Maternity	Inadequate Aug 2018	Good Aug 2018	Good Aug 2018	Good Sept 2018	Inadequate Aug 2018	Inadequate Aug 2018
Services for children and young people	Requires improvement → ← Jun 2018	Requires improvement → ← Jun 2018	Good → ← Jun 2018	Requires improvement ↓ Jun 2018	Requires improvement ↓ Jun 2018	Requires improvement → ← Jun 2018
End of life care	Good → ← Jun 2016	Requires improvement → ← Jun 2016	Good → ← Jun 2016	Good → ← Jun 2016	Good → ← Jun 2016	Good → ← Jun 2016
Outpatients	Good Jun 2016	N/A	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Overall*	Requires improvement ↓ Aug 2018	Requires improvement → ← Aug 2018	Good → ← Aug 2018	Requires improvement ↑ Aug 2018	Requires improvement ↓ Aug 2018	Requires improvement ↓ Aug 2018

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

Ratings for Ealing Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓ Aug 2018	Requires improvement →← Aug 2018	Good →← Aug 2018	Requires improvement →← Aug 2018	Inadequate ↓ Aug 2018	Inadequate ↓ Aug 2018
Medical care (including older people's care)	Inadequate ↓ Aug 2018	Requires improvement →← Aug 2018	Requires improvement ↓ Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018
Surgery	Requires improvement ↓ Aug 2018	Requires improvement ↑ Aug 2018	Good →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018
Critical care	Good →← Oct 2015	Good →← Oct 2015	Good →← Oct 2015	Requires improvement →← Oct 2015	Good →← Oct 2015	Good →← Oct 2015
Services for children and young people	Requires improvement ↑ Aug 2018	Requires improvement ↓ Aug 2018	Good →← Aug 2018	Good ↑ Aug 2018	Requires improvement ↓ Aug 2018	Requires improvement →← Aug 2018
End of life care	Good →← Oct 2015	Requires improvement →← Oct 2015	Good →← Oct 2015	Good →← Oct 2015	Good →← Oct 2015	Good →← Oct 2015
Outpatients	Good →← Oct 2015	N/A	Good →← Oct 2015	Good →← Oct 2015	Good →← Oct 2015	Good →← Oct 2015
Overall*	Inadequate ↑ Jun 2018	Requires improvement ↓ Jun 2018	Good →← Jun 2018	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018

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

Ratings for Central Middlesex Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good Aug 2014	N/A	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014
Medical care (including older people's care)	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014
Surgery	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014
Critical care	Good Aug 2014	Requires improvement Aug 2014	Good Aug 2014	Good Jun 2014	Requires improvement Aug 2014	Requires improvement Aug 2014
Services for children and young people	Requires improvement Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014	Requires improvement Aug 2014	Requires improvement Aug 2014
End of life care	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014
Outpatients	Good Aug 2014	N/A	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014
Overall*	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014	Requires improvement Aug 2014	Good Aug 2014

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

Ratings for community health services

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

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

Northwick Park Hospital

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Key facts and figures

London North West University Healthcare NHS Trust is one of the largest integrated care trusts in the country, bringing together hospitals and community services across Brent, Ealing and Harrow. The trust employs more than 9,000 clinical and support staff and serves a diverse population of approximately one million people. The trust operates at three acute sites: Northwick Park Hospital, Ealing hospital and Central Middlesex hospital.

The trust has 1,260 beds including 66 children's beds and neonatal care cots, 68 maternity beds, 33 critical care beds.

Northwick Park hospital serves an ethnically diverse population mainly concentrated in the London Borough of Harrow.

Northwick Park Hospital provides the following services:

- Urgent and emergency care
- Medical care (including older peoples care)
- Surgery
- Maternity and gynaecology
- Outpatients and diagnostics
- Critical care
- End of life care
- Children's and young people services.

Summary of services at Northwick Park Hospital

Requires improvement 

Our rating of services stayed the same. We rated it them as requires improvement because:

- We rated caring at Northwick Park hospital as good. We rated safe, effective, responsive and well-led as requires improvement.
- Critical care improved from requires improvement to good.
- Maternity went down from requires improvement to inadequate.

Summary of findings

- Urgent and emergency services, medical care, surgery and children and young people's services remained as requires improvement.
- We rated well-led as inadequate in medical care and maternity.
- We rated safe as inadequate in maternity services.

Urgent and emergency services

Requires improvement 

Key facts and figures

The emergency department at Northwick Park Hospital provides care for the local population 24 hours a day, seven days a week.

Between January 2017 and December 2017, the trust had 189,861 attendances, an average of 520 patients a day. In the same reporting period , 18.5% of attendees were admitted to hospital, which was lower than the national average of 18.7%.

The department includes a paediatric emergency department dealing with all emergency attendances under the age of 17 years. Attendances of children under 17 in the last 12 months was 36,962

Patients present to the department either by walking into the reception area or arrive by ambulance via a dedicated ambulance-only entrance. Patients transporting themselves to the department are seen initially by a triage nurse (Triage is the process of determining the priority of patients' treatments based on the severity of their condition).

The department has different areas where patients are treated depending on their needs, including an urgent care centre (UCC), Majors (here called the High Dependency Unit (HDU)), minors (here called the Assessment Unit), Resuscitation (resus), Clinical Decision Unit (CDU), and the Paediatric Emergency Department (PED) with its own waiting area and bays is within the department.

We visited the ED over three days during our announced inspection. We looked at all areas of the department and we observed care and treatment. We looked at 31 sets of patient records. We spoke with 52 members of staff, including nurses, doctors, allied health professionals, managers and support staff. We also spoke with 11 patients and 10 relatives who were using the service at the time of our inspection. We reviewed and used information provided by the organisation in making our decisions about the service.

Summary of this service

Our rating of this service stayed the same. We rated it it as requires improvement because:

- Mandatory training compliance was still poor for medical staffing and did not meet the trust target. This included safeguarding training.
- The department still faced significant issues with ambulance turnaround which led to high numbers of black breaches.
- There was evidence that the department reported incidents. However, similar to the previous inspection we were not always assured lessons learnt were embedded into practice. Some staff reported they did not receive feedback from incidents they reported.
- Effective risk management arrangements were not in place for mental health patients and this placed patients at risk of unsafe care and treatment. The process for ensuring emergency department staff completed one to one observations of patients was not robust.
- The band 5 nursing vacancy rate was high.
- Some guidelines on the trust intranet had not been reviewed and were out of date.

Urgent and emergency services

- Pain scores were not always documented in the paediatric emergency department. We found sometimes there was no evidence of pain scores or pain relief for children with painful conditions.
- The department were performing below the national average in many of the Royal College of Emergency Medicine (RCEM) audits. We were told there were plans to re-audit a number of them but this had not yet taken place.
- Appraisals rates were poor and below the trust target for nursing staff.
- We did not see much health promotion information around the department.
- The department did not meet the target to admit, discharge, or transfer 95% of patients within four hours between in any of the 12 months preceding or inspection.
- Patients were still waiting for long periods before staff moved them to an appropriate ward or department once a decision to admit and been made. Access to services and patient flow continued to be a significant problem for the department and patients experienced long waits. The clinical decisions unit was often being used inappropriately for patients waiting for beds within the hospital.
- Some staff raised concerns about the culture in the department. Some staff felt they were not listened to by the trust, especially when it came to decisions about service development.
- There were no joint governance meetings between the emergency department and the urgent care centre. This meant learning from serious incidents was not shared with the urgent care centre.
- There was now clinical governance at a departmental level. However, we were not assured this was as effective as it could be because things such as risk, incidents and complaints were not standing agenda items.

However:

- Staff understood how to protect patients from abuse. Staff knew how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- Staff monitored patients who were at risk of deteriorating appropriately. Early warning scores were in use in both adult and paediatric areas.
- Multidisciplinary working was evident in most areas of the department.
- Staff were professional and care for patients in a caring and compassionate manner. Feedback from patients and relatives was positive.
- The department had a frailty pathway, supported by specialists, to safely reduce admissions and length of stay for elderly patients and ambulatory care pathways.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- At the last inspection we found staff recognised incidents and knew how to report them. Managers investigated incidents quickly. However, we were not assured lessons and actions were shared in the department. We found this was still the case and were not assured learning from incidents was embedded within the culture of the department.

Urgent and emergency services

- Mandatory training compliance was still poor for medical staffing and did not meet the trust target. This included safeguarding training compliance.
- The department still faced significant issues with ambulance turnaround which led to high numbers of black breaches. However, the department had introduced a number of measures to reduce ambulance delays which had improved turnover times.
- Effective risk management arrangements were not in place for mental health patients and this placed patients at risk of unsafe care and treatment. The process for ensuring emergency department staff completed one to one observations of patients was not robust.
- The mental health room was based in the middle of the clinical decisions unit (CDU). It was reported that when patients were aggressive or distressed this could be overheard by patient on CDU.
- The band 5 nursing vacancy rate was high. Staff reported at times the department did not feel safe due to staffing levels.

However:

- Staff kept patients safe from harm and abuse. They understood and followed procedures to protect vulnerable adults or children.
- The department was clean and equipment well maintained. Staff followed infection control policies that managers monitored to improve practice.
- At the last inspection we found there was no information displayed to advise patients on what to do if their condition deteriorated. We saw information in the waiting room advising patients to contact staff if they felt more unwell as they waited.
- Medicines were stored securely and staff followed appropriate procedures for controlled drugs.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- Managers monitored the effectiveness of care and treatment through continuous local and national audits. However, the hospitals performance in some of the national audits were in the lower quartile of trusts. The hospital and failed to meet standards in a number of audits including acute severe asthma, consultant sign off and procedural sedation in adults. Clinical leaders told us there were actions to address this.
- From March 2017 to February 2018, the trust's unplanned re-attendance rate to accident and emergency within seven days was worse than the national standard of 5% and also consistently worse than the England average. However, between March 2018 and June 2018 this had been improving.
- Pain scores were not always documented for children attending the department with painful conditions.
- Appraisal rates for nursing staff in the emergency department were lower than the trust target of 85%
- Mental capacity training and deprivation of liberty training compliance for medical staff was poor. However, doctors said there was good access to training and support for professional development.

However:

Urgent and emergency services

- Staff provided care and treatment based on national guidance and evidence and used this to develop new policies and procedures. There were a number of care bundles in department for patients with specific conditions such as sepsis.
- Staff displayed good knowledge of the treatment of patients presenting with sepsis. On two occasions during the inspection we saw staff appropriately following the sepsis six protocol.
- Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other preferences.
- We saw examples of good multidisciplinary working. Doctors, nurses and other healthcare professionals supported each other to provide care. The involvement of other teams such as the on-site psychiatric liaison team and frailty team helped to improve the patient experience.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Is the service caring?

Good  

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

- Patients, families and carers were positive about the care across the service and we observed compassionate and courteous interactions between staff and patients.
- Patients and relatives told us staff were respectful and helpful and gave them regular updates.
- Observations of care showed staff maintained patient privacy and dignity. Staff explained what they were doing at all times and allowed patient and relatives opportunities to ask questions.
- Staff provided emotional support to patients and relatives and could signpost them to services within the organisation as well as external organisations for additional support.

Is the service responsive?

Requires improvement  

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

- The departments performance for Department of Health's target of 95% of patients admitted, transferred or discharged within four hours of arrival was poor. From April 2017 to March 2018 the trust consistently failed to meet the standard, and performed worse than the England average in all but one month.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. Similar to the last inspection the trust consistently failed to meet the standard, and consistently performed worse than the England average, from March 2017 to February 2018.
- From April 2017 to March 2018 the trust's monthly median total time in A&E for all patients was consistently worse than the England average.

- There were five patients at the emergency department who waited more than 12 hours from decision to admit until being admitted
- There were still issues with patient flow in the department. Patients were waiting for long periods of time in the department and experienced delays accessing beds within the hospital.

However:

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- The department had a frailty pathway, supported by specialists, to safely reduce admissions and length of stay for elderly patients and ambulatory care pathways.

Is the service well-led?

Requires improvement 

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

- Whilst staff told us they were encouraged to report incidents we were not assured learning from incidents was embedded within the culture of the department. Some staff said they did not receive feedback from incidents and we were found some incident of patients absconding had not been reported as incidents.
- The department had still persistently been unable to deliver the national four hour target for patients to be seen, treated, admitted and discharged. Whilst some improvements had been made performance was consistently below the England average.
- The service did not have a clear strategy that all staff understood and put into practice.
- Staff and managers were clear about the challenges the department faced. They explain the risks to the department and the plans to deal with them. However, the risk register did not contain all risks we found in the department.
- Some staff highlighted issues with the culture of the department. Issues with bullying was mentioned by some staff and a lack of support from band 7 nurses.
- Effective risk management arrangements for mental health patients were not in place and this placed patients at risk of unsafe care and treatment. The process for ensuring emergency department staff completed one to one observations of patients was not robust.

However;

- The emergency department had a clear management structure at both divisional and departmental level. The managers knew about the quality issues, priorities and challenges.
- At the last inspection governance arrangements were at a trust wide level. We found they were now more departmentally focused, but needing some further development.

Areas for improvement

Actions the provider MUST take to improve

- Must review the processes, implementation and recording of observations of mental health patients in the ED department.

- Ensure that there are effective systems in place for learning from incidents.

Actions the provider SHOULD take to improve

- Ensure that patient records detail the care and treatment provided including a record of drink and food provided.
- Make sure the mental health assessment room provides a therapeutic environment.
- Improve compliance with mandatory training especially for medical staff.
- Improve on pain assessments and timely administration of pain relieving medicines in paediatric emergency department.
- Improve the recording of pain scores in the paediatric emergency department
- Improve appraisal rates.
- The trust should continue to work towards improving flow and capacity within the ED to improve performance against the national target.
- Reduce the number of black breaches
- The trust should continue to proactively manage recruitment and retention of nursing staff.
- The trust should consider how to improve IT systems across the department to enable easier sharing of information.
- Ensure the departments risk register incorporates all risks to the department and each risk is monitored robustly.

Medical care (including older people's care)

Requires improvement 

Key facts and figures

The inpatient medical and older people's inpatient services at Northwick Park Hospital includes acute medicine, respiratory, gastroenterology, neurology and stroke, care of the elderly, cardiology, endocrinology, rheumatology, and haematology. The Dryden high dependency unit (HDU) came under both integrated and emergency medicine.

The endoscopy department at St Marks Hospital undertakes diagnostic and major therapeutic gastroscopy (OGD), colonoscopy, flexible sigmoidoscopy, endoscopic retrograde cholangio pancreatogram (ERCP), bronchoscopy & double balloon enteroscopy (DBE).

The trust also has a regional hyper acute rehabilitation unit which is a level 1 complex specialist rehabilitation service commissioned by NHS England. The unit admits patients from major trauma centres, hyper-acute stroke units, neurosciences centres as well as district general hospitals in London, Eastern (Bedfordshire, Hertfordshire and Essex) and Southern (Berkshire) regions.

Northwick Park Hospital has 511 medical inpatient beds located across 22 wards and units.

Ward/unit	Specialty	Inpatient beds
Carroll Ward	**Urgent medicine**	**22**
Catheterisation laboratory	**Cardiology**	**8**
Coronary care unit	**Cardiology**	**8**
Clarke Ward	**Escalation ward**	**16**
Crick Ward	**Medical assessment unit**	**26**
Darwin Ward	**Medical assessment unit**	**26**
Defoe Ward	**Infectious diseases**	**10**
Dickens Ward	**Medical assessment unit**	**34**
Dryden Ward	**Urgent medicine**	**21**
Elgar Ward	**Infectious diseases**	**15**
Endoscopy	**Diagnostic pathology**	**29**
Fielding Ward	**Care of the elderly**	**38**
Fletcher Ward	**Gastroenterology medicine**	**30**
Gaskell Ward	**Respiratory medicine**	**28**
Haldane Ward	**Stroke medicine**	**34**
Hardy Ward	**Care of the elderly**	**34**

Medical care (including older people's care)

Herrick Ward	**Stroke rehab medicine**	**25**
James Ward	**Endocrinology and rheumatology**	**34**
Jenner Day Care	**Cardiology**	**0**
Jenner Ward	**Cardiology**	**35**
Kingsley Ward	**Clinical haematology**	**14**
Fleming Ward (Regional Hyper Acute Rehabilitation Unit)	**Rehabilitation**	**24**

(Source: Routine Provider Information Request - Acute-Sites)

The trust had 74,005 medical admissions from January to December 2017. Emergency admissions accounted for 26,423 (35.7%), 1,175 (1.6%) were elective, and the remaining 46,407 (62.7%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 27,345 admissions
- Gastroenterology: 26,799 admissions
- Clinical haematology: 6,118 admissions

Northwick Park Hospital had 33,620 medical admissions from January to December 2017. Emergency admissions accounted for 19,732 (58.7%), 475 (1.4%) were elective, and the remaining 13,413 (39.9%) were day case.

Admissions for the top three specialties were:

- General Medicine: 19,532 admissions
- Medical Oncology: 4,680 admissions
- Clinical Haematology: 3,743 admissions

(Source: Hospital Episode Statistics)

During the inspection we visited Carroll ward, Catheterisation laboratory, Clarke ward, Crick ward, Darwin ward, Defoe ward, Dickens ward, Dryden ward, Dryden HDU, Elgar ward, Endoscopy, Fielding ward, Fletcher ward, Haldane ward, Hardy ward, Herrick ward, Jenner ward, Kingsley ward and the regional hyper acute rehabilitation unit

During this inspection we spoke with 63 staff including health care assistants, doctors, nurses, allied health professionals and ancillary staff. We also spoke with the directorate leadership team. We spoke with 17 patients and 11 relatives. We reviewed 17 patient records and 27 medication administration records. We made observations and looked at documentary information accessible within the department and provided by the trust.

Summary of this service

Our rating of this service stayed the same. We rated it it as requires improvement because:

Medical care (including older people's care)

- Leaders had failed to manage the high demand for the service and high bed occupancy, the service was still struggling to cope. Leaders had failed to address the length of stay for elective patients at Northwick Park Hospital.
- Four risks identified on the risk register in 2017 and 2016 concerned the environment none of which related to the aging estate which did not always provide the best environment for providing care. Following the previous inspection we reported the environment of the stroke wards needed improving. During this inspection we found the stroke wards environment still needed improving.
- The risk register did not include some of the concerns we found during the inspection including staff levels across the wards, mandatory training compliance and the movement of patients at night.
- Most staff in the medical services knew the trust values. However most staff we spoke with were unaware of the integrated medicines divisional strategy. This was similar to what we found at the last inspection.
- Although the service had taken action to address staff shortages, those actions had to date not resulted in improvements in permanent staff numbers.
- Although the trust had systems for identifying risks and plans to mitigate risks, this did not always translate to improvements within the service. For example, there were inconsistencies in relation to document completion across the wards, kitchens, sluices and clean utility rooms were locked or unlocked, out of date medicines.
- A total of 7,138 patients were moved at night between 11.00pm and 8.00am during the period 1st January 2017 to 31st December 2017. This means the trust was not focussed on getting patients a bed on a ward for their speciality.
- The trust informed did not have data for the last year (2017) showing whether ward moves were due to non-clinical reasons.
- From January 2017 to December 2017 the average length of stay for medical elective patients at Northwick Park Hospital was 13.5 days, which was longer than England average of 5.8 days.
- The trust took an average of 43.1 working days (mean) to investigate and close these complaints. The trust responded to 45.4% of complaints within the target period of 40 working days. This is not in line with their complaints policy, which states that 80% of complaints should be responded to within 40 working days
- The service did not have enough permanent nursing staff to ensure the provision of safe care and treatment. However, the service used bank and agency staff to cover gaps in the staffing provision.
- Mandatory training in key skills for nursing staff was below the trust targets of 85% in three of the 10 core training areas. The overall completion rate was 80%. This was similar to what we found at the last inspection.
- Mandatory training in key skills for medical staff was below the trust targets of 85% in none of the nine core training areas. The overall completion rate was 38%. This was similar to what we found at the last inspection.
- Safeguarding adults level 2 training for medical staff was below the trust target of 85%. The completion rate was 58%.
- Hand hygiene compliance was variable across the medical wards was monitored across the wards. Compliance varied from between 100% to 50%.
- Care records were not being completed consistently. Some staff did not understand how to use all parts of the care record and were adding signatures to care plans without highlighting the specific aspects of the plan that were relevant.
- Out of date medicines including a controlled drug (CD) which was a liquid medicine was found. This had a four-week expiry after opening. There was no opening date or expiry date on the bottle.

Medical care (including older people's care)

- The temperature of ward fridges were consistently being recorded at more than eight degrees which meant that fridge temperatures were out of range and medicines were not being stored at the correct temperature.
- There was not a systematic approach to keeping trust policies and guidelines up to date, which meant the trust could not be assured that staff were working with the latest guidance. We found this was similar during the previous inspection.
- Fluid balance charts and malnutrition universal screening tool MUST assessments were not being completed consistently. We found this was similar in during the previous inspection.
- The number of qualified nursing staff who had an appraisal in the period was 72.3% which was below the trust target of 85%.
- The number of medical staff who completed the training was 57.5% which was below the trust target of 85%. However there had been an improvement since the last inspection in the number of nursing staff (92.7%) completing Mental Capacity Act training in the period April 2017 to January 2018,
- We observed that patients on beds were sometimes transported in public lifts which meant visitors waiting for lifts saw these patients, which unnecessarily compromised their privacy and dignity.
- We observed phones were unanswered on some wards. We did not know who calls were from but two relatives said it was difficult to get an answer when they rang the ward.
- Signage to wards was sometimes misleading, and had not been updated to reflect where wards had been relocated. There was no sign to Kingsley ward (the haematology ward) in the lifts or on the list of wards beside the map. There were no signs on lifts that were meant for staff use only.

However:

- There was a clear governance structure. The integrated medical division was responsible for all medical services across the three hospital sites within the trust and was led by a divisional clinical director, divisional general manager and divisional head of nursing, who worked across all three of the trusts sites.
- Patients were being continually being assessed using the National Early Warning System (NEWS). Staff were knowledgeable in responding to any changes in the observations which necessitated the need to escalate the patient to be seen by medical staff or the critical care outreach team.
- Serious incidents (SIs) were discussed as part of the monthly medicine clinical divisional quality and risk meetings clinical governance. SIs were investigated, had an action plan and lesson learnt identified.
- Northwick Park Hospital consistently achieved grade A for overall performance for the Sentinel Stroke National Audit programme (SSNAP) over the six audit periods from October 2015 to July 2017. On a scale of A-E, where A is best.
- Patients prescribed pain relief to be given 'when required' were able to request this when they needed it. Patient notes recorded whether patients had been asked about pain.
- There was effective multidisciplinary team (MDT) working in the ward areas. Relevant professionals were involved in the assessment, planning and delivery of patient care. We found this had improved since the last inspection.
- We saw clinical staff treat people with dignity, respect and kindness during their stay on the wards. Staff were seen to be considerate and empathetic towards patients. Most of the patients we spoke with were positive about the staff that provided their care and treatment.
- From March 2017 to February 2018 the Friends and Family Test (FFT) response rate for medical care at Northwick Park Hospital was 41%. This was based on 6,737 responses. This was higher than the England average of 25%.

Medical care (including older people's care)

- Most of the wards had day rooms or visitors room which staff could use to break bad news or have confidential conversations with relative. We saw staff providing emotional support to patients and relatives.
- Most patients we spoke with said they felt involved in their care. Relatives we spoke to were mostly happy with the care their relatives received and felt they had been kept involved with their loved ones' treatment.
- The service took account of the needs of different people. Staff had received training in dementia and there was a mental health specialist nurse who provided advice relating to patients with mental health needs and an activities co-ordinator. Patients had access to translation services and relatives of elderly patients stay overnight.
- The care of the elderly wards Fielding and Hardy had been made more dementia friendly using the Kings Fund environmental assessment tool.
- Dickens ward had recently been restructured when the ward became a frailty medical assessment unit where elderly patients would be discharged after a short stay. The ward was aiming for a high daily discharge rate
- Staff felt valued, supported and spoke highly of their jobs despite the pressures; Staff told us there was good team work and peer support and it was better when fully staffed, but when short staff it could be very stressful and it made their job much harder.
- There was a culture of honesty, openness and transparency. We saw evidence of senior staff carrying out duty of candour responsibilities
- Staff felt valued, supported and spoke highly of their jobs despite the pressures; Staff told us there was good team work and peer support and it was better when fully staffed, but when short staff it could be very stressful and it made their job much harder.
- There was a culture of honesty, openness and transparency. We saw evidence of senior staff carrying out duty of candour responsibilities.

Is the service safe?

Requires improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service did not have enough permanent nursing staff to ensure the provision of safe care and treatment. However, the service used bank and agency staff to cover gaps in the staffing provision.
- Mandatory training in key skills for nursing staff was below the trust targets of 85% in three of the 10 core training areas. The overall completion rate was 80%. This was similar to what we found at the last inspection.
- Mandatory training in key skills for medical staff was below the trust targets of 85% in none of the nine core training areas. The overall completion rate was 38%. This was similar to what we found at the last inspection.
- Safeguarding adults level 2 training for medical staff was below the trust target of 85%. The completion rate was 58%.
- Hand hygiene compliance was variable across the medical wards was monitored across the wards. Compliance varied from between 100% to 50%.
- Care records were not being completed consistently. Some staff did not understand how to use all parts of the care record and were adding signatures to care plans without highlighting the specific aspects of the plan that were relevant.

Medical care (including older people's care)

- Out of date medicines including a controlled drug (CD) which was a liquid medicine was found. This had a four-week expiry after opening. There was no opening date or expiry date on the bottle.
- The temperature of ward fridges were consistently being recorded at more than eight degrees which meant that fridge temperatures were out of range and medicines were not being stored at the correct temperature.

However

- Patients were being continually being assessed using the National Early Warning System (NEWS). Staff were knowledgeable in responding to any changes in the observations which necessitated the need to escalate the patient to be seen by medical staff or the critical care outreach team.
- Serious incidents (SIs) were discussed as part of the monthly medicine clinical divisional quality and risk meetings clinical governance. SIs were investigated, had an action plan and lesson learnt identified.

Is the service effective?

Requires improvement  

Our rating of effective stayed the same. We rated it as requires improvement because:

- The number of medical staff who completed the training was 57.5% which was below the trust target of 85%. However there had been an improvement since the last inspection in the number of nursing staff (92.7%) completing Mental Capacity Act training in the period April 2017 to January 201817.
- There no a systematic approach to keeping trust policies and guidelines up to date, which meant the trust could not be assured that staff were working with the latest guidance. We found this was similar during the previous inspection.
- Fluid balance charts and malnutrition universal screening tool MUST assessments were not being completed consistently. We found this was similar in during the previous inspection.
- The number of qualified nursing staff who had an appraisal in the period was 72.3% which was below the trust target of 85%.

However:

- Northwick Park Hospital consistently achieved grade A for overall performance for the Sentinel Stroke National Audit programme (SSNAP) over the six audit periods from October 2015 to July 2017. On a scale of A-E, where A is best.
- Patients prescribed pain relief to be given 'when required' were able to request this when they needed it. Patient notes recorded whether patients had been asked about pain.
- There was effective multidisciplinary team (MDT) working in the ward areas. Relevant professionals were involved in the assessment, planning and delivery of patient care. We found this had improved since the last inspection.

Is the service caring?

Good  

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

Medical care (including older people's care)

- We saw clinical staff treat people with dignity, respect and kindness during their stay on the wards. Staff were seen to be considerate and empathetic towards patients. Most of the patients we spoke with were positive about the staff that provided their care and treatment.
- From March 2017 to February 2018 the Friends and Family Test (FFT) response rate for medical care at Northwick Park Hospital was 41%. This was based on 6,737 responses. This was higher than the England average of 25%.
- Most of the wards had day rooms or visitors room which staff could use to break bad news or have confidential conversations with relative. We saw staff providing emotional support to patients and relatives.
- Most patients we spoke with said they felt involved in their care. Relatives we spoke to were mostly happy with the care their relatives received and felt they had been kept involved with their loved ones' treatment.

However:

- We observed that patients on beds were sometimes transported in public lifts, which meant visitors waiting for lifts saw these patients, which unnecessarily compromised their privacy and dignity.
- We observed phones were unanswered on some wards. We did not know who calls were from but two relatives said it was difficult to get an answer when they rang the ward.

Is the service responsive?

Requires improvement 

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

- A total of 7,138 patients were moved at night between 11.00pm and 8.00am during the period 1st January 2017 to 31st December 2017. This means the trust was not focussed on getting patients a bed on a ward for their speciality.
- From January 2017 to December 2017 the average length of stay for medical elective patients at Northwick Park Hospital was 13.5 days, which was longer than England average of 5.8 days.
- The trust took an average of 43.1 working days (mean) to investigate and close these complaints. The trust responded to 45.4% of complaints within the target period of 40 working days. This is not in line with their complaints policy, which states that 80% of complaints should be responded to within 40 working days.
- Signage to wards was sometimes misleading, and had not been updated to reflect where wards had been relocated. There was no sign to Kingsley ward (the haematology ward) in the lifts or on the list of wards beside the map. There were no signs on lifts that were meant for staff use only.

However

- The service took account of the needs of different people. Staff had received training in dementia and there was a mental health specialist nurse who provided advice relating to patients with mental health needs and an activities co-ordinator. Patients had access to translation services and relatives of elderly patients stay overnight.
- The care of the elderly wards Fielding and Hardy had been made more dementia friendly using the Kings Fund environmental assessment tool.
- Dickens ward had recently been restructured when the ward became a frailty medical assessment unit where elderly patients would be discharged after a short stay. The ward was aiming for a high daily discharge rate.

Medical care (including older people's care)

Is the service well-led?

Requires improvement 

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

- Leaders had failed to manage the high demand for the service and high bed occupancy, the service was still struggling to cope. Leaders had failed to address the length of stay for elective patients at Northwick Park Hospital.
- Four risks identified on the risk register in 2017 and 2016 concerned the environment none of which related to the aging estate which did not always provide the best environment for providing care. Following the previous inspection we reported the environment of the stroke wards needed improving. During this inspection we found the stroke wards environment still needed improving.
- The risk register did not include some of the concerns we found during the inspection including staff levels across the wards, mandatory training compliance and the movement of patients at night.
- Most staff in the medical services knew the trust values. However most staff we spoke with were unaware of the integrated medicines divisional strategy. This was similar to what we found at the last inspection.
- Although the service had taken action to address staff shortages, those actions had to date not resulted in improvements in permanent staff numbers.
- Although the trust had systems for identifying risks and plans to mitigate risks, this did not always translate to improvements within the service. For example, there were inconsistencies in relation to document completion across the wards, kitchens, sluices and clean utility rooms were locked or unlocked, out of date medicines.

However:

- There was a clear governance structure. The integrated medical division was responsible for all medical services across the three hospital sites within the trust and was led by a divisional clinical director, divisional general manager and divisional head of nursing, who worked across all three of the trusts sites.
- Staff felt valued, supported and spoke highly of their jobs despite the pressures; Staff told us there was good team work and peer support and it was better when fully staffed, but when short staff it could be very stressful and it made their job much harder.
- There was a culture of honesty, openness and transparency. We saw evidence of senior staff carrying out duty of candour responsibilities.

Areas for improvement

Actions the provider SHOULD take to improve

- The service should ensure safe levels of staff to ensure the provision of safe care and treatment.
- The service should ensure there is consistency in relation to document completion across the wards in particular fluid balance charts and malnutrition universal screening tool assessments.
- The service should ensure medical staff understand their roles and responsibilities in relation to the Mental Capacity Act 2005.
- The service should ensure mandatory training for medical and nursing staff meets the trust target of 85%.

Medical care (including older people's care)

- The service should take action to reduce patients' length of stay on medical wards.

Surgery

Requires improvement 

Key facts and figures

Northwick Park Hospital has 208 surgical inpatient beds across nine wards and units and provides care in six specialties. There is a dedicated emergency surgery and trauma service that operates 24-hours, seven days a week and the hospital is a national specialist centre for maxillo-facial, ear, nose and throat and vascular surgery. The hospital has one private surgical ward, which we included in our inspection.

To come to our ratings, we spoke with 43 members of staff, including those in clinical and non-clinical roles as well as staff at all levels of experience and seniority. We spoke with 12 patients and seven relatives and reviewed 13 sets of clinical notes and prescription records. We also considered over 80 other pieces of evidence, including audits and performance records.

During our inspection we visited all surgical inpatient wards and theatre pre-operative and assessment areas. We also included the Sainsbury Wing, which primarily provides care for non-NHS patients. St Mark's Hospital, which is part of the Northwick Park Hospital site, holds a separate registration with CQC and we were therefore unable to include surgical services within that hospital's remit.

Summary of this service

Our rating of this service stayed the same. We rated it it as requires improvement because:

- Completion of mandatory training was variable and medical staff did not meet the trust's target in any subject with some significantly below the standard.
- Although there was evidence of learning from incidents and mistakes, outcomes did not always ensure practice was fully in line with national guidance or fully mitigate future risks of recurrence.
- Staff knowledge and understanding of trust policies, or where to find them, was inconsistent and five serious incidents had been reported because of a failure to follow standards.
- Theatre safety processes were audited and found between January 2018 and May 2018 the lead surgeon did not stay in the theatre for the final count of swabs and other items in 51% of the audit sample.
- From December 2016 to November 2017 patients at Northwick Park Hospital had a higher than expected risk of readmission for elective admissions compared to the national average. However, the risk of readmission for non-elective patients was better than the national average.
- Patients and relatives told us communication with doctors could be improved, particularly at weekends and when they were concerned about mental health needs.
- There was a lack of clinical governance and leadership oversight in theatres that had led to lapses in electrical safety and medicines management.

However:

- Risk management tools and procedures were embedded in practice and contributed to patient safety. This included tools to assess patient suitability for surgery and use of international standards, such as the World Health Organisation safer surgery checklist.

Surgery

- The trust had restructured areas in which we previously found concern and improved medical staffing cover to ensure specialist clinical needs were met.
- There was a clear drive to deliver care in a culture that valued safety, openness and honesty. This included learning from incidents and good standards of dissemination of investigation outcomes.
- Clinical staff demonstrated a drive to improve data quality for audits to ensure benchmarking and audit processes were accurate and vigorous. This included through internal exercises and externa peer review.
- Multidisciplinary working was extensive and was part of day-to-day care and treatment as well as governance and risk management.
- We observed consistently friendly, kind and compassionate care delivered by staff who understood how to facilitate privacy and dignity.
- The hospital performed better than the national average for surgical referral to treatment times in 18 week specialty care pathways.

At our last inspection in October 2015 we told the trust they must:

- Ensure staff, including consultants, always reported incidents.
- Improve consultant radiologist cover at weekends.
- Improve rates of mandatory training, including in the Mental Capacity Act (2005).
- Improve the recording of nutrition and hydration.
- Improve data completeness for bowel cancer surgery.
- Ensure final checks of swab counts and instruments are undertaken with verbal confirmation before the surgeon de-scrubs.
- Develop appropriate surgical care pathways.
- Develop and communicate the vision and strategic aims of the surgical directorate to all staff.

At this inspection the trust provided evidence incident reporting had increased steadily over the previous three years and evidence that consultant radiologist cover had been improved at weekends. In addition, we saw consistently good standards of documentation for nutrition and hydration and processes to improve data management in cancer care. Specialist teams had also developed new evidence-based surgical care pathways. However, rates of mandatory training were variable and were very low for doctors in some subjects. In addition, surgical safety audits indicated the lead surgeon did not always remain in theatres for the final verbal count of swabs.

Is the service safe?

Requires improvement 

Our rating of safe improved. We rated it as requires improvement because:

- Nurse training in resuscitation and basic life support was significantly lower than the 85% minimum trust standard, with an overall average of 76% completion.
- Mandatory training rates for doctors were very low and the team did not meet the trust's 85% target in any training area.

Surgery

- Infection control in relation to the environment was not always consistently managed, including in relation to the disposal of curtains.
- There was not a system in place to ensure electrical equipment was always checked and maintained for safety.
- Staff demonstrated variable knowledge of fire safety and we found low levels of compliance with basic fire safety management in some areas.
- Nurse vacancy, sickness and turnover rates were higher than the trust target.
- Medicines management in theatres was not in line with trust policies or national best practice guidance and some practices placed patients at increased risk.
- Although we found improved standards of incident reporting, it was not evident senior staff always included healthcare assistants in incident-reporting. There was sometimes limited evidence of learning from serious incidents and five had occurred in a 16-month period as a result of a failure to follow policies and procedures.
- Although staff had implemented new processes as learning from a never event, practice did not follow guidance from the Royal College of Anaesthetists with regards to documentation for throat packs.

However:

- At our last inspection in 2015 we found staff did not always submit incident reports, which meant the service could not track themes or identify areas of risk. At this inspection we found incident-reporting had improved and was more embedded in practice.
- Doctor vacancy, sickness and turnover rates were better than the trust target and the trust had implemented weekend cover by a consultant radiologist.
- We observed generally good infection control and hand hygiene practices by staff, including in the use of the aseptic non-touch technique.
- Staff consistently used established risk management tools to contribute to good patient safety.
- Senior teams were responsive to updates to national guidance and standards and managed their teams accordingly to maintain a safe service.
- Two guardians for safe working hours were in post and used annual reports to highlight the need for junior doctors to more consistently record excessive, unsafe working hours.
- Staff in multiple teams and roles demonstrated an understanding of never events and serious incidents and knew about the changes to practice that resulted from learning outcomes.

Is the service effective?

Good 

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

- The senior team continually reviewed existing policies against national standards and engaged in benchmarking, including through peer review.
- There was a proactive approach to developing care pathways and practices through new evidence-based initiatives, such as through the creation of a 'sepsis squad' and participation in a national older people's surgery programme.

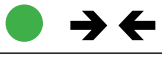
Surgery

- Theatre teams audited the use of the World Health Organisation surgical safety checklist on a weekly basis as a benchmarking tool to establish minimum standards in each team.
- Between March 2017 and February 2018, the surgical specialties performed consistently better than the national average and the trust average in the referral to treatment time within 18 weeks. In this period four out of seven specialties performed better than the national target of 90%.
- Surgical safety audits between January 2018 and May 2018 indicated consistently good practice in line with trust standards, except for the role of the lead surgeon.
- Staff had access to ongoing professional development through trust and external training courses. Nurses were encouraged to develop clinical competencies and specialist skills and junior doctors had regular protected teaching time led by consultants.
- The specialist palliative care team had increased training and development opportunities for all staff to help them recognise when patients were coming to their end of their life and provide appropriate care.
- Surgical teams implemented a range of improvements in evidence-based practice following the results from a 'getting it right first time' (GIRFT) peer review.
- We found consistently good standards of nutrition and hydration in relation to documentation, monitoring and patient care.

However:

- There was no pre-operative fasting policy in place and the process of scheduling elective procedures meant patients sometimes fasted for significantly longer than necessary.
- Although evidence indicated a focus on maintain up to date policies and procedures we found staff did not always have access to these and were unaware of them in some cases. In addition, five serious incidents had been reported in a 16-month period that involved a failure to follow trust policies.
- The hospital performed worse than national averages and did not meet aspirational standards in the 2017 national hip fracture database.
- Patients in colorectal surgery had a higher than expected risk of readmission for elective admissions when compared to the national average.
- Medical staff demonstrated low levels of completion of Mental Capacity Act (2005) training and did not meet the trust target of 85%.

Is the service caring?

Good 

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

- Between March 2017 to February 2018 the Friends and Family Test response rate for surgery was 48%; significantly better than the national average.
- During this period all surgical wards performed consistently well and received a recommendation rate of over 90%.
- During our observations we saw staff treated patients and their relatives with kindness and compassion and maintained their dignity and privacy.

Surgery

- All of the patients and relatives we spoke with said they were happy with the care and compassion shown by staff.
- Patients told us staff referred them for formal psychological assessment and support on request or if their mental health declined.
- A multi-faith chaplaincy service was available 24-hours, seven days a week.
- During our observations of ward rounds we saw doctors introduced themselves to patients and explained what they were doing and why.

However:

- Some patients said they felt communication could be improved in wards, including with regards to the compassion of some individual staff.
- Three relatives we spoke with said they did not feel that staff always understood the mental health needs of patients or the impact of treatment on their mental wellbeing. We also received variable feedback about the involvement of patients by doctors or more broadly at the weekend.

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good because:

- At our last inspection in 2015 we found targets for referral to treatment times (RTTs) were not being met. At this inspection we found between March 2017 to February 2018 the hospital's referral to treatment time (RTT) for admitted pathways for surgery was 88%, which was better than the national average and compared with the rest of the trust. The RTT for all seven specialities was better than the national average.
- Resources for patients living with dementia on inpatient wards had improved since our last inspection.
- The average length of stay for elective and non-elective patients in 2017 was similar to the national average overall.
- The emergency surgery team provided a 24-hour, seven-day dedicated service led by nurse practitioners and a medical team.
- Services and resources had been restructured to more closely meet the needs of the local population, including out of hours radiology, improved care in the intensive recovery unit and a 'fast track' day surgery area.
- The specialist palliative care team provided specialised on-demand care and treatment for patients and worked with community teams and Macmillan nurses to ensure a seamless service.
- Staff on Sainsbury Wing, a private ward, provided care and treatment that did not compromise safety based on patients' level of insurance cover.
- Discharge planning was structured and multidisciplinary.
- Adapted equipment was available on each ward to help people at mealtimes such as colour-contrasting crockery for patients living with dementia and menus printed in Braille and 11 different languages.
- Staff were supported to use their broader skills to make patients more comfortable in addition to their clinical role.
- In the previous year the hospital treated all patients whose procedure had been cancelled within 28 days of the original date, which is significantly better than the national average.

Surgery

However:

- Serious incident reports indicated the hospital could not always meet individual patient needs, including due to a lack of capacity in the tissue viability team and barriers to communicating with patients living with a living disability.
- Nurses in some surgical wards felt they did not have the training or resources to meet the needs of medical patients cared for as outliers, such as when patients required specialist respiratory support.
- Average lengths of stay for elective patients in maxillo-facial surgery and colorectal surgery were longer than the national averages.

Is the service well-led?

Requires improvement 

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

- Staff demonstrated an understanding of the main risks to their services, practice and patients and said they felt listened to when they raised these with the senior team. However, they said they did not feel action was often taken nor that risks to patients were always effectively mitigated.
- Risks staff experienced on wards were not always reflected in the risk register. This was also the case in risks such as low levels of mandatory compliance by the medical team.
- Senior teams could not demonstrate consistent safety oversight in relation to equipment. This included equipment with expired or missing electrical safety certificates.
- Managers failed to monitor and challenge consultant decisions to cancel operations.
- There were gaps in communication between the ward team on Sainsbury Wing and senior staff at divisional level, which meant problems obtaining medical review out of hours had not been resolved.
- There was a lack of senior-level oversight of fire safety and environmental risk management.
- Medicine management in theatres did not always demonstrate safe practice and governance systems had not addressed this.

However:

- Staff had developed governance and risk management processes that included detailed patient case reviews as part of morbidity and mortality reviews. Reviews considered the influence of human, system and patient factors.
- All of the staff we spoke with felt positively about their leadership team and said they received continuous support.
- At our last inspection in 2015 we found staff did not know about the trust vision and strategy. At this inspection staff said they felt part of the trust's vision and strategy and were able to explain how it applied to their work and career goals.
- Staff in all areas and teams described the working culture as positive and conducive to learning, development and establishing good working relationships.
- The senior team facilitated monthly divisional clinical governance days as part of their overall strategy of improving governance, incident reporting and quality assurance.

- Clinical nurse managers and matrons carried out a red, amber, green (RAG)-based quality assurance assessment for each ward to benchmark standards in five areas, which they rated on a sliding scale as part of a broader quality assurance programme.

Outstanding practice

- Staff demonstrated a focus on opportunities for improvement and dedication to adapting national pilots and new strategies to their patient group. For example, the theatre assess/admit unit matron had completed a study event on the proactive older person surgery (POPS), a national multidisciplinary strategy to improve the experience and clinical outcomes of older patients. The matron had established a working relationship with cardiology and planned to replicate this with the geriatrician team. In another example the emergency surgery team were participating in the national fluid management in emergency laparotomy trial, which we saw was discussed at each multidisciplinary meeting.
- As part of their significant increase in training and development opportunities for ward-based teams, the specialist palliative care team was developing a link ward to facilitate more supervision and support for surgical inpatient wards.
- The matron responsible for Edison, Eliot and Dowland wards and the SAU had supported their teams in the implementation of an innovative 'make a difference' project to improve quality standards and opportunities for joint working. As part of this, clinical nurse managers had shadowed each other to gain insight into their respective areas of work and band six nurses had worked collaboratively on a development programme.

Areas for improvement

The trust MUST:

- Improve medicines management to include regular, documented checks of the temperature in storage areas including refrigerators.
- Address the low levels of compliance with mandatory training amongst the medical team. We identified this as an area for the trust to improve in our last inspection in October 2015.
- Ensure sufficient nursing staff have up to date training in basic and immediate life support.
- Implement a system to ensure all equipment is regularly inspected, safe and fit for purpose.

The trust SHOULD:

- Review how staff access policies and procedures to reduce the likelihood of serious incidents resulting from a failure to follow accepted practice.
- Ensure healthcare assistants have access to incident-reporting systems and understand how to use them.
- Ensure infection control practices are consistent and protect patients and staff from the risks associated with bacteria growth and cross-infection.
- Ensure trust doctors who carry the on-call bleep out of hours are fully aware of the need to respond to calls from staff working in the Sainsbury Wing.
- Ensure monitoring and challenge to consultant decisions to cancel operations.
- Ensure staff understand fire safety procedures, including the purpose and use of fire doors.
- Ensure patients and those close to them remain up to date with care and treatment plans from the medical team.

Critical care

Good ↑

Key facts and figures

The critical care service sits in the surgery division and is managed by a clinical lead, a lead nurse and a matron. There were 884 admissions to the critical care unit (CCU) between May 2017 and April 2018. Critical care encompasses intensive care and high dependency levels of support. Northwick Park Hospital critical care unit provides a total of 24 adult inpatient beds across the two intensive care units. Floor level three with 11 intensive care beds and floor level five with five intensive care beds as well as a six bedded high dependency unit (HDU) and two side rooms. There are six beds in the Dryden unit HDU which came under both integrated and emergency medicine.

A critical care outreach team is available 24 hours a day, seven days a week to assess and support the care of deteriorating patients prior to their transfer to critical care and also to follow up patients discharged from the unit.

We inspected the service over three announced inspection days, 05 to 07 June 2018.

During our inspection, we spoke with 35 members of staff including doctors, nurses, allied health professionals and other staff. We spoke with the clinical lead and matron for the service. We reviewed 11 patient records and spoke with three patients and nine relatives.

Summary of this service

Our rating of this service improved. We rated it it as good because:

- Since the last inspection, there was improvement in certain aspects of flow. The proportion of out of hours discharges had significantly reduced from 14% at that time to the current 2.0%.
- There was also significant improvement in non-clinical transfers out to another critical care unit. Intensive Care National Audit Research Centre (ICNARC) data between April 2017 and 31 December 2017 showed this was 0.2%, when it was reported as10 times the national average at the last inspection. The recent data compared favourably with similar units which was 0.4% and nationally which was 0.3%.
- There was evidence of improved multidisciplinary working across the service.
- One hundred per cent of patients were reviewed by a consultant within 12 hours of admission to the CCU in accordance with the faculty of intensive care medicine (FICM) recommendations.
- Managers shared learning from incidents with staff and staff had an opportunity to reflect on how they could improve.
- The critical care outreach team provided a 24 hour a day seven days a week service to patients. They followed up 95% patients within 24 hours when they moved to a ward.
- There was a positive and friendly culture on the unit. We observed good team working amongst staff of all levels. Staff told us that they were proud to work for the hospital and were well supported by their colleagues.
- Staff treated patients with kindness and compassion. Feedback from patients was consistently positive about the care they had received on the unit.

However:

Critical care

- Patient flow through critical care was still a significant issue. 13% of patients were delayed for more than the recommended four hours and 38% of patients waited over 24 hours before being discharged to a ward. This was attributed to lack of bed capacity in the rest of the hospital.
- Incidents of mixed sex accommodation breaches were only recently being recorded and investigated appropriately.
- The CCU was an outlier for delayed discharges; the number of patients who waited more than 24 hours from decision to discharge for transfer to a bed on a ward was higher than the national average.
- The unit's risk register did not reflect all the risks we identified during our inspection. For example, we found that the restricted bed space in the high dependency unit was not included.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- Limited availability of hand basins in wards on level 5 and the proximity of beds in the high dependency unit (HDU) meant there was an increased risk of cross-contamination.
- The reduced space between beds in the HDU meant there were restrictions on the types of equipment which could be used at the bedside.
- The most recent data available from the Intensive Care National Audit Research Centre (ICNARC) showed there was an upward trend in unit acquired infections in the blood; 3.3 compared with 0.8 in the previous reporting period.
- Not all staff had completed their mandatory training. The trust's 85% target for staff completion of mandatory training was not met for several training modules including, safeguarding children level 2, conflict resolution and resuscitation. Compliance was particularly low for medical staff.
- Incidents of mixed sex accommodation breaches were only recently recorded and investigated appropriately.
- There was no recognised system in place to share learning from incidents across the trust.

However:

- 100% of patients were reviewed by a consultant within 12 hours of admission to the CCU in accordance with the faculty of intensive care medicine (FICM) recommendations.
- The critical care outreach team provided a 24 hour a day seven days a week service to patients. They followed up 95% patients within 24 hours when they moved to a ward.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care. There was good documentation of safety monitoring results to detect patient deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Is the service effective?

Good 

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

Critical care

- Multidisciplinary (MDT) working across the service had improved and was embedded in the day to day operation of the unit. We observed daily ward rounds were attended by doctors, nurses and allied healthcare professionals. We also observed the weekly MDT meeting which included representatives from other specialties in addition to CCU staff.
- There was improved evidence of consistent usage of appropriate risk assessments and care bundles to reduce the risk of patient harm. Compliance with care bundles including ventilator associated pneumonia, central venous catheters and visual infusion phlebitis score was between 90% and 100%.
- Staff followed national professional standards and guidelines to achieve the best possible outcomes for patients receiving care and treatment on the unit.
- The critical care service participated in national and local benchmarking to measure performance and identify areas for improvement.
- Policies and procedures were updated at regular intervals to reflect current best practice and guidance and were accessible on the trust intranet.
- The CCU used planned sedation holds, which controlled the use of sedation whilst maintaining the optimal level of patient comfort.
- Nursing staff were compliant with MCA and DoLS training.

However:

- The unplanned readmission to critical care within 48 hours of discharge was worse when compared with results for similar units and nationally.
- There was no facility to provide patients with parenteral nutrition (the delivery of calories and nutrients into a vein) over the weekend since the aseptic unit, which made up the nutrition did not cover weekends.
- There was an increase in the risk adjusted hospital mortality ratio from 1.0 to 1.7 between the most recent two reporting periods.
- There was low compliance with MCA and DoLS training for medical staff.

Is the service caring?

Good ➔➔

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

- Results from the Friends and Family Test responses exceeded the trust standard and 100% of respondents reported they would recommend the service.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress.
- Staff communicated clearly and frequently with patients and relatives.

However:

- Patient privacy and dignity was sometimes compromised since beds were in such close proximity to each other.

Critical care

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good because:

- Since the last inspection, there was improvement in certain aspects of flow. The proportion of out of hours discharges at that time was 14% at that time compared with the current 2.0%.
- The proportion of out of hours discharges for non-clinical reasons was 10 times the national average at the time of the last inspection. The current rate was 0.4% and which compared favourably with the national figure of 0.3%.
- Ninety five per cent of patients were admitted to the CCU within four hours of making the decision to admit.
- There was a dedicated critical care outreach team which supported the unit 24 hours a day seven days a week.
- The CCU ran follow-up clinics which provided support and guidance on any physical or psychological impact to patients of their time spent on the unit.

However:

- The CCU was an outlier for delayed discharges; 38% of patients waited more than 24 hours from decision to discharge for transfer to a bed on a ward compared with the national average which was19%. We were told that patients were held on the ward due to lack of bed capacity in the rest of the hospital.
- We were told there were multiple occurrences of mixed sex breaches as a result of delayed charges. Collection of data just began in May 2018 and we saw there were 16 reported breaches.
- Bed occupancy between March 2017 and February 2018 averaged 80% which was not in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) recommendation of 70% critical care occupancy.

Is the service well-led?

Good ↑

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

- There was improved flow in areas which were identified as significant issues at the last inspection. This included out of hours discharges and transfer out to other critical care units for non-clinical reasons.
- Ninety three percent of patients were admitted to the CCU within four hours. The faculty of intensive care medicine (FICM) recommends that admission to critical care should occur within four hours of making the decision to admit as it is associated with better outcomes.
- There was improved bed capacity in the critical care unit since the last inspection.
- Staff we spoke with told us that local managers were visible, approachable, supportive and proactive.
- There was a positive and friendly culture on the unit. We observed good team working amongst staff of all levels. Staff told us that they were proud to work for the hospital and were well supported by their colleagues.
- We saw evidence of learning and continuous improvement on the unit. Staff were encouraged to take time out to reflect on what went well, learn from errors, and work together to resolve problems.

- There was a robust governance structure with evident multidisciplinary team engagement.

However:

- Patient flow out of critical care was still a significant issue and the unit was an outlier for delayed discharges.
- We were not assured that there was a robust process in place to maintain oversight of delayed discharges and mixed-sex accommodation breaches.
- There was no recognised system for trust wide sharing and learning from incidents.

Areas for improvement

Actions the provider MUST take to improve:

- Address the environmental issues in the high dependency unit to ensure they are fit for purpose in line with statutory requirements and should take account of national best practice.

Actions the provider SHOULD take to improve:

- Work to improve compliance with mandatory training for medical and nursing staff.
- Work to improve patient flow through the critical care unit.
- Work to reduce mixed sex breaches on the ward.
- Improve trust wide sharing and learning from incidents.

Maternity

Inadequate 

Key facts and figures

The maternity service at Northwick Park Hospital consists of an obstetric-led delivery suite, a midwife-led birth centre and Florence obstetric ward. There is also a foetal medicine unit, day assessment unit, maternity theatres and recovery and an obstetric observation bay.

The trust has 69 maternity beds, all located at Northwick Park Hospital. These are made up of:

- 19 beds on the delivery suite
- 31 beds on the Florence obstetric ward
- 19 beds on the midwife-led birth centre

(Source: Trust Provider Information Request – Acute sites)

From January 2017 to December 2017 there were 4,789 deliveries at the trust.

A comparison of the number of deliveries at the trust to all other trusts in England during this period is shown below.

Number of babies delivered at London North West Healthcare NHS Trust – Comparison with other trusts in England

A profile of all deliveries and gestation periods from October 2016 to September 2017 can be seen in the tables below.

Profile of all deliveries (January 2017 to December 2017)

	LONDON NORTH WEST HEALTHCARE NHS TRUST		England
	Deliveries (n)	**Deliveries (%)**	**Deliveries (%)**
Single or multiple births			
Single	**4,722**	**98.6%**	**98.5%**
Multiple	**67**	**1.4%**	**1.5%**
Mother's age			
Under 20	**102**	**2.1%**	**3.0%**
20-34	**3,605**	**75.3%**	**74.8%**
35-39	**858**	**17.9%**	**18.1%**
40+	**224**	**4.7%**	**4.1%**

Maternity

Total number of deliveries		
Total	**4,789**	**593,637**

Notes: A single birth includes any delivery where there is no indication of a multiple birth.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

Gestation periods (January 2017 to December 2017)			
	LONDON NORTH WEST HEALTHCARE NHS TRUST		**England**
	Deliveries (n)	**Deliveries (%)**	**Deliveries (%)**
Gestation period			
Under 24 weeks	*	*	**0.1%**
Pre term 24-36 weeks	**139**	**3.8%**	**7.9%**
Term 37-42 weeks	**3,497**	**96.1%**	**91.8%**
Post Term >42 weeks	*	*	**0.2%**
Total number of deliveries with a valid gestation period recorded			
Total	**3,639**		**492,201**

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

Number of deliveries at London North West Healthcare NHS Trust by quarter.

SOURCE: HES - Deliveries (January 2017 - December 2017)

There was no overall trend in the quarterly number of deliveries over this period.

We last inspected London Northwest Hospitals NHS Trust maternity services in October 2015. We found maternity services required improvement overall. The purpose of this inspection was to see if the services performance had been maintained or if any improvements had been made by the service since the previous inspection.

The previous inspection included maternity services at Ealing Hospital and gynaecology services. It should be noted that this report relates to maternity services at Northwick Park Hospital only.

Maternity

Summary of this service

Our rating of this service stayed the same. We rated it it as requires improvement because:

- We found systems, policies and procedures in the response to emergency paediatric crash calls via 2222 were not disseminated appropriately to all staff within the hospital and were not operated effectively.
- Robust systems were not in place to ensure the security of the maternity unit. There was a risk that unauthorised people could gain access to theatres and the delivery suite via the theatre lift. Electronic doors on the main entrance could be pulled open at night by force and used by members of the public. During our unannounced inspection 14 June 2018, we were informed that security would be present at night at the entrance of the maternity to ensure that people do not enter the department. This was only an interim arrangement as permanent security solutions had not been decided or actioned.
- There was no security on the doors between the delivery suite and theatres. This meant there was a risk of unauthorised access to both areas.
- During our previous inspection in October 2015 we reported that mandatory training compliance was below the trust's required standards. During this inspection we found mandatory training targets were still not being met by all maternity staff.
- The flooring in the toilets in the antenatal clinic was also loose in places and posed an infection control risk.
- We saw that straps on the cardiotocography (CTG) machine were not changed between patients, this posed a risk of cross infection from one patient to another.
- There were no 'tailgating' notices on maternity wards. This created the risk of unauthorised people gaining access to the maternity wards.
- The trust did not have an abduction policy for maternity. This meant staff may not know how to respond in the event of an infant or child abduction or suspected abduction.
- There was no alert system in place for staff working in the community who may require support whilst working off-site.
- The trust's 'shoulder dystocia guideline' did not clarify which teams would attend an obstetric crash call.
- Between February 2017 and January 2018 there were 39 complaints about maternity. The trust took an average of 46 working days to investigate and close complaints, this was not in accordance with their complaints policy.
- The service did not have an open culture that welcomed review, where staff felt able to challenge each other in a friendly environment. Managers told us cultural considerations had been secondary to ensuring clinical governance systems were developed and embedded within the service.
- Some staff said they felt there was a lack of consultation and communication by the divisional leadership and new working practices had been imposed on staff.
- Managers and senior staff told us there had been tensions between some band 7 maternity staff and managers. Some senior midwifery staff told us they felt unable to challenge staff or take ownership of their department.
- Risks on the risk register were not actioned in a timely way or at the earliest opportunity.

However:

Maternity

- During our previous inspection in October 2015 we reported 'fresh eye' checks were not always being carried out for women in labour. During this inspection we found the checks had been completed in accordance with best practice recommendations.
- During our previous inspection we reported that staff did not always get feedback when the reported incidents. However, during this inspection we found improvements as incidents were widely reported and openly discussed with staff.
- During our previous inspection in we found women's pain scores were not recorded in their care records. During this inspection we found improvements in the recording of pain scores.
- During our previous inspection we reported that the trust's 85% standard for staff appraisals was not met. During this inspection we found this had improved and the trust's standard was being met across maternity services.
- During our previous inspection we reported the area used for triaging patients was not big enough to accommodate patient flow. However, during this inspection we found the triage area had recently been developed to facilitate women's journey through maternity.
- During our previous inspection we reported that antenatal clinics frequently ran over two hours late. During this inspection we found improvements with women waiting between 15 and 45 minutes for their appointment.
- The trust had achieved UNICEF Baby Friendly accreditation and was working towards the gold award.
- As of April 2018, the trust had no active maternity outliers.
- In response to the 'Better Births' national maternity review (NHS England 2016). The birth centre had introduced caseloading.
- Work was in progress on a bereavement room that would be completed in June 2018 and available to parents who had suffered the loss of a baby.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate because:

- We found staff in maternity and the trust's switchboard team, who were responsible for dispatching staff in the event of an emergency, had inconsistent knowledge of responding to an obstetric or paediatric crash call. Following our inspection, the trust took action to address some of our concerns. However, we were not assured that there was a robust system in place to ensure that the correct staff were bleeped in response to an emergency on an ongoing basis.
- We had security concerns in regards to the environment at the maternity department. For example, the main doors to the maternity department were electronically operated and could be forced open. Following our unannounced inspection on 14 June 2018 the trust had a security guard in place between the hours of 7.00pm and 7.00am. The security guard would remain in place until a long-term solution to the doors security had been agreed. However, following our inspection the trust informed us the doors were being replaced on 31 July 2017.
- There were three lifts in the maternity building. One of the lifts was a theatre lift and could only be called by staff with a swipe card. However, we saw members of the public get into the lift on three occasions. Following our inspection, the trust assured us that 'no public access' notices had been displayed on the theatre lift and staff had been emailed a reminder to direct the public to other public lifts with immediate effect.

- There was no security on the doors between the delivery suite and theatres. This meant there was a risk of unauthorised people gaining access to these areas via the theatre lift.
- There was no security system to ensure only authorised staff could gain access from the delivery suite to theatres.
- During our previous inspection in October 2015, we reported 'fresh eye' checks were not consistently being carried out for women in labour. During this inspection, we found women's records we reviewed had these checks completed in accordance with best practice recommendations.
- During our previous inspection we reported that staff did not always get feedback when the reported incidents. However, during this inspection we found improvements as incidents were widely reported and openly discussed with staff.
- There was no improvement in relation to mandatory training. We found the same evidence as at the previous inspection that mandatory training targets were not being met. For example, from April 2017 to January 2018 the trust's 85% compliance standard was met for two of the nine mandatory training modules for which midwives were eligible. However, the 85% compliance standard was not met for any of the seven mandatory training modules for which medical staff in maternity were eligible.
- The trust did not have an abduction policy for maternity. This meant staff may not know how to respond in the event of an infant or child abduction or suspected abduction.
- There was a lack of tail gating notices on all wards and departments. These are notices at the entrance to wards and departments that remind staff and the public not to allow other people access to the ward by entering when the doors are opened.
- The floor covering in the antenatal clinic toilet was loose due to wear and tear and posed an infection control risk.
- There was no alert system in place for community midwifery staff whilst working off-site.

However:

- A team of specialist safeguarding midwives worked across both Northwick Park and Ealing hospitals. Level three safeguarding children training had been completed by 95% of clinical staff against a requirement of 85%. Safeguarding adults level two training had been completed by 92% of staff.
- Staff completed risk assessments to help women choose their preferred place of delivery, recommend further investigations and inform a plan of care. This included whether a patient should have midwife or consultant led care or be referred to other professionals within the multidisciplinary team.
- All women had a named consultant (for high-risk pregnancies) or a named midwife (for low risk pregnancies).
- Overall, the maternity service managed medicines appropriately. The pharmacist visited daily and checked drugs and charts. However, we found a few fluids where the date had expired in May 2018 on the delivery suite. We also found a medicine used in the induction of labour being disposed of incorrectly by staff pouring it down the sink and not using yellow clinical waste bins.
- Incidents were widely reported and openly discussed. Staff discussed incidents at handovers and morning meetings.
- All staff we spoke to were aware of their responsibilities relating to Duty of Candour (DoC) under the Health and Social Care Act (Regulated Activities Regulations) 2014.

Maternity

Is the service effective?

Good  

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

- During our previous inspection in October 2015, we found pain scores were not consistently recorded in the care records we looked at. During this inspection, we found improvements in the recording of patients' pain scores.
- During our previous inspection we reported that the trust's 85% standard for staff appraisals was not met. During this inspection we found this had improved and the trust's standard was being met across maternity services.
- Overall, staff provided care in line with the National Institute for Health and Care Excellence (NICE) quality standard 22. This standard covers the care of all women up to 42 weeks of pregnancy. The standard covers all areas of antenatal care including community and hospital settings.
- The service adhered to The Abortion Act 1967 and the Abortion Regulations 1991. We saw the correct completion of HSA1 form, which were signed by two doctors before admission. The correct procedure was also followed for the HAS4 form which was sent to the Department of Heath after completion. The service did not carry out termination of pregnancy on women where there was indication a fetus was over 21 weeks.
- The trust had achieved United Nations Children's Fund (UNICEF) 'Baby Friendly' accreditation and was working towards the gold award. The Baby Friendly Initiative is based on a global accreditation programme of UNICEF and the World Health Organization (WHO). It is designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care.
- In the 2017 National Neonatal Audit programme (NNAP) 91.3% of all mothers were given a complete or incomplete course of antenatal steroids. This was better than expected when compared to the national aggregate of 86.1%.
- From October 2016 to September 2017, the total number of caesarean sections (CS) was similar to the 12% expected rate for both elective and emergency caesareans.
- Mothers who deliver babies below 30 weeks gestation being given magnesium sulphate in the 24 hours prior to delivery was higher than the national aggregate of 43.5% The trust results of 57.1% put the hospital in the top 25% of all units.
- As of April 2018, the trust had no active maternity outliers.
- The trust took part in the 2017 Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE) audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 4.67. This was more than 10% lower than the average rate of 5.19 for the comparator group. This was much better than expected.
- There were comprehensive training and education opportunities available to staff. The trust employed two dedicated maternity education lead midwives. New midwives joining the trust completed a comprehensive preceptorship programme.
- Maternity services had introduced a new model of midwifery supervision. All supervisors of midwives were transferring to the professional maternity advocate (PMA) role. PMA are experienced practising midwives trained to support and guide midwives to deliver care developed nationally and locally
- Staff demonstrated awareness of what actions to take in the event of a patient lacking the capacity to consent. Staff understood the use of 'Gillick competencies' in relation to young people.

However:

Maternity

- The trust's 'shoulder dystocia guideline' did not clarify which teams would attend an obstetric crash call. The switchboard team told us they would only dispatch the paediatric crash team upon specific request. Staff said this was because paediatrics were not required for all obstetric emergencies, as sometimes the call was for the mother and did not involve the baby. However, maternity staff were unaware that they had to make a specific request for the paediatric crash team. This meant the guideline did not clarify to all staff which teams should be dispatched to a crash call and which teams needed to be specifically requested.
- During our previous inspection we reported the service was not meeting the trust's 1.5% home births standard. We found that from April 2017 to May 2018 the trust's standard was still not being met.

Is the service caring?

Good ➔➔

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

- Patients and relatives we spoke with consistently told us about the kindness of the staff across maternity services.
- Women using the trust's maternity services were treated with dignity and respect. Staff maintained women's privacy and dignity by drawing curtains around women before undertaking examinations or providing care.
- The trust scored about the same as other trusts for 15 questions of the 19 questions in the CQC maternity survey 2017. The trust scored worse than other trusts for the remaining four questions.
- Midwifes told us they could signpost women or their partners to 'talking therapies' with 'Mind', the mental health charity, and local counselling services. Women were assessed for any extra care needs they may require at booking with the community midwives. This included an assessment for post-natal anxiety and depression.
- The trust had a team of bereavement midwives who supported women and their families following stillbirth or neonatal death.
- Staff communicated with women and their families making sure they understood the treatment they were to receive and the risks associated with this.

Is the service responsive?

Good ➔

Our rating of responsive improved. We rated it as good because:

- During our previous inspection in October 2015 we reported the area used for triaging patients was not big enough to accommodate patient flow. However, during this inspection we found the triage area had recently been developed to facilitate women's journey through maternity.
- During our previous inspection we reported that antenatal clinics frequently ran over two hours late. During this inspection we found improvements with women waiting between 15 and 45 minutes for their appointment.
- The birth centre provided care for women with a low risk pregnancies and natural birth. The birth centre was led by a team of midwives that specialised in natural birth. The birth centre offered 1:1 midwifery care with access to medical assistance if needed.

Maternity

- In response to the 'Better Births' national maternity review (NHS England 2016). The birth centre had introduced case loading. This is a model of care where midwives carry their own caseload of women to form trusting relationships and provide care throughout the woman's experience of pregnancy and childbirth up to 28 days' following the birth of their baby.
- Work was in progress on a bereavement room which would be completed and available to parents who had suffered the loss of a baby in June 2018.
- The department had pathways of care for women with learning disabilities. Women were identified at the booking stage and offered advice and extra support where required.
- Patients with mental health issues were placed on a care pathway and had regular contact with the perinatal mental health team. An alert was placed on the system so anytime the patient contacted the department staff were aware of their extra needs and care could be planned.

However:

- Community midwifery services had been restricted from nine midwives in GP surgeries to five midwives in Children's Centres. Managers told us there had been some opposition from staff to the change. Although there had not been any impact on patients.
- From July 2016 to December 2017, the bed occupancy levels for maternity at the trust were consistently higher than the England average. Over quarter three of 2017/18 the trust's bed occupancy rate was 62.7% compared to the England average of 58.9%.
- Between February 2017 and January 2018 there were 39 complaints about maternity. The trust took an average of 46 working days to investigate and close complaints, this is not in accordance with their complaints policy, which states complaints should be responded to and closed in less than 40 days. However, we also found 41% of complaints were responded to and closed in less than 40 working days.

Is the service well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate because:

- Managers were aware of the security issues in relation to the maternity unit but no action had been taken to resolve those issues.
- The lack of clarity and the confusion in the crash call incident that we witnessed demonstrated that not enough attention to essential processes had been given by the leadership of the service.
- We were concerned at the lack of visibility of the service leadership within the department and the lack of visibility of the senior trust leadership.
- Risks on the risk register were not actioned in a timely way or at the earliest opportunity.
- Managers told us maternity services were in transition. There had been several changes to the governance structure in recent times.
- Staff told us that members of the directorate and local leadership teams were not visible. There had been a change in the structure of maternity management from a model where there was a Head of Midwifery (HoM), to a model where there was a maternity operations director supported by a deputy divisional lead.

Maternity

- The division had some historical cultural issues dating back to the merger of Ealing Hospital and Northwick Park Hospital. Senior managers told us there had been a culture clash for some staff resulting from the merger.
- Managers told us cultural considerations had been secondary to ensuring clinical governance systems, process and procedures were developed and embedded within the service.
- The service did not have an open culture that welcomed review, where staff felt able to challenge each other. Some staff said they felt there was a lack of consultation and communication by the divisional leadership and new working practices were imposed on staff.
- We were concerned that no measures had been taken to successfully resolve tensions and poor relationships within the service particularly in relation to potential impact on patient safety and patient experience.
- Managers and senior staff told us there had been tensions between some band 7 maternity staff and managers. Some senior midwifery staff told us they felt unable to challenge staff or take ownership of their department.

However:

- Managers told us work was in progress on designing a maternity services 'philosophy of care.' Managers said it was a priority that the service formed a collective identity.
- The trust had introduced a new set of values. These were known to staff as 'heart' values. The values, "putting patients as the HEART of everything we do." All the staff we spoke with were aware of the new values. Although a few members of the midwifery staff told us they had not been invited to attend the 'heart' values and customer care training.
- The trust had governance frameworks across all the clinical divisions.
- The service had an obstetric improvement plan in place.
- The consultant midwife had conducted a strengths, weaknesses, opportunities, threats (SWOT) analysis. As a result, the service had introduced fortnightly staff engagement meetings for: preceptors, students, band 7, and general midwives.
- The trust had introduced a 'behaviour framework' and this set out the behaviour expected of all staff at the trust.

Outstanding practice

The trust was engaged in 'Wave 2' of the 'Maternal and Neonatal Health Safety Collaborative'. This was a National Health Service Improvement (NHSI) initiative. The three-year programme aimed to support improvement in the quality and safety of maternity and neonatal units across England.

Areas for improvement

Actions the provider MUST take to improve

- Ensure robust systems are in place to ensure that the correct staff are bleeped on an ongoing basis including a system of regular checks of the bleep system to ensure that the correct staff are bleeped at all times.
- Ensure robust systems are in place to ensure unauthorised persons cannot gain access to theatres via use of the staff/ theatre lift.
- Ensure the doors to the delivery suite from theatres are by secure access only.
- Ensure the main doors to the maternity unit cannot be forced open at any time of the day or night.

Maternity

Actions the provider SHOULD take to improve

- Ensure staff mandatory training meets trust standards.
- Ensure there is an abduction policy for maternity and ensure staff know how to respond in the event of an infant or child abduction or suspected abduction.
- Ensure there are tail gating notices on all wards and departments.
- Ensure the floor covering in the antenatal clinic toilet does not pose an infection control risk.
- Ensure there is an alert system in place for community midwifery staff working off-site.
- Ensure emergency guidelines clarify which teams will attend emergency calls and disseminate this to staff.
- Ensure all patient complaints are investigated and closed within the trust's published policy timescales.
- Ensure there is increase visibility of divisional and local leads.
- Take steps to improve working relationships within the service.
- Prioritise cultural improvements within the maternity team.
- Ensure identified risks on the risk register are actioned in a timely way or at the earliest opportunity.

Services for children and young people

Requires improvement 

Key facts and figures

Northwick Park Hospital is part of the London North West Healthcare NHS Trust, established on 1 October 2014 from the merger of North West London NHS Trust and Ealing Hospitals NHS Trust. The trust employ more than 8,000 staff it serves a diverse population of approximately 850,000 across the boroughs of Brent, Ealing and Harrow.

Between January and December 2017, the trust had 10.138 spells in the children and young people's services, 8,569 of which were at Northwick Park Hospital. Following the closure of the Accident and Emergency department and children's inpatient ward at Ealing Hospital in 2016 there was an expansion in the services provided at Northwick Park Hospital, with an increase in children's inpatient beds and the provision of a paediatric assessment unit.

Children and young people's services at Northwick Park Hospital (NPH) consist of a children's ward for inpatient care called 'Jack's Place', a 27-bedded medical/surgical ward with 12 side rooms. A paediatric assessment unit was located within the children's accident and emergency department contained four beds and cared for children for up to 24 hours.

The children's day care unit and outpatient area (Chaucer) at this hospital is a nine-bedded area with outpatient facilities to provide surgical and medical day care to children and young people from birth to 16 years of age. The unit is open Monday to Friday between the hours of 8am and 6pm.

The neonatal intensive care unit (NICU) is a level two unit, for babies born prematurely or for newborn babies that have difficulties or are unwell. NICU has capacity to take up to 28 babies, with eight cots for intensive care and high dependency care and the remainder cots for special care. The ward hosted a new transitional care unit with three beds and cots.

We visited the children and young people's service over three days during our announced inspection between 5 and 7 June 2018 and during an unannounced inspection on 20 June 2018. We looked at all areas of the department and we observed care and treatment. We looked at 15 sets of patient records. We spoke with 28 members of staff, including consultants, doctors, nurses, allied health professionals, managers and domestic and administrative staff. We also spoke with 15 patients and 10 relatives who were using the service at the time of our inspection. We reviewed and used information provided by the organisation in making our decisions about the service.

Summary of this service

Our rating of this service stayed the same. We rated it it as requires improvement because:

- Mandatory training completion rates for nursing and medical staff were not meeting the trust target.
- Processes and systems could not always be relied upon to protect children from abuse and harm. Children on the child protection register were not always identified, and arrangements for vulnerable patients between 16 and 18 years were not robust.
- There was a lack of appropriate assessment for children with mental health concerns during nights and weekends, which meant they may stay in hospital longer than necessary.
- Nursing vacancies were high across all areas of the service, with a high turnover rate between January and December 2017. This led to a high proportion of bank and agency staff being used to fill shifts.

Services for children and young people

- Nutrition and hydration assessments were not always completed. We found gaps in feeding charts and the frequency of patient assessment reviews.
- The pain tool, used by the service to assess and manage pain, was not consistently completed and reviewed.
- The children and young people's service did not have a nursing lead for patients with a learning disability or mental health concern. Advice was sought from the Children and Adolescent Mental Health Service Monday to Friday, but there was no support at night or weekends.
- The service did not always provide a smooth and timely transition for patients moving between children and adult services. The trust did not have a transition policy and staff felt that guidelines required clarity.
- Bed space capacity during the winter months was not meeting the increasing demand, particularly for patients with higher and more complex needs. The inpatient ward was providing high dependency care although this was not yet funded and there was no designated area.
- Senior leaders of the trust were rarely seen on the children and young people's wards. Medical staff told us there was no forum for them to raise ideas or concerns with the senior leadership team.
- Audits were regularly undertaken within the service to check that guidelines were being followed. However, robust action plans were not always put in to place when gaps were identified.
- The service did not have a forum for children and young people, and their carers, to provide feedback about the care and treatment received at the hospital.
- Most staff within the children and young people's service said that communication could be improved. In particular, staff said ward meetings did not always go ahead. Emails with a brief summary were sent out to staff who missed meetings.

However:

- All areas within the children and young people's service were visibly clean, and we found infection control protocols were adhered to.
- Paediatric early warning scores were routinely recorded to identify patients that may be deteriorating.
- We saw evidence of good multidisciplinary working throughout all areas of the children and young people's service. Psychosocial and complex case meetings discussed the social and psychological wellbeing of patients.
- We observed compassionate care being provided across all areas of the children and young people's service by nursing and medical staff.
- Children and their carers felt fully involved in their care and treatment. Doctors and nurses explained procedures in a relaxed and child friendly manner.
- Transitional care was provided on the neonatal ward, enabling mothers to stay with their baby whilst receiving hospital care, and preparing for discharge.
- The service had won a national patient experience network award for its' use of technology and actively engaging with adolescent users of the diabetes services. This had led to a reduction in patient non-attendance at the diabetes clinics.

Is the service safe?

Requires improvement 

Services for children and young people

Our rating of safe stayed the same. We rated it as requires improvement because:

- Mandatory training completion rates for nursing and medical staff were not meeting the trust target.
- Processes and systems could not always be relied upon to protect children from abuse and harm. Children on the child protection register were not always identified, and arrangements for vulnerable patients between 16 and 18 years were not robust.
- Safeguarding mandatory training rates for medical staff were below the trust target. The safeguarding training strategy was not in date.
- There was a lack of appropriate assessment for children with mental health concerns during nights and weekends, which meant they may stay in hospital longer than necessary.
- Nursing vacancies were high across all areas of the service, with a high turnover rate between January and December 2017. This led to a high proportion of bank and agency staff being used to fill shifts.
- The service had difficulty filling vacancies for middle grade doctors. Consultant cover was low on the neonatal unit, leading to undue pressure at times of consultant absence. The trust were recruiting to a further post through the medical training initiative at the time of our inspection.
- Risk assessments on patient records were not always fully completed or reviewed routinely.
- Key messages from incidents were discussed during handovers and ward meetings. However, some staff said that communication regarding incidents was not always relayed in a formal manner.

However:

- All areas within the children and young people's service were visibly clean, and we found infection control protocols were adhered to.
- Equipment on the wards was clean and up to date, with appropriate checks carried out in the majority of cases.
- Paediatric early warning scores were routinely recorded to identify patients that may be deteriorating.
- Medicines were stored securely. Actions were being taken to reduce medication errors. However, training rates for medicine management were still not meeting the trust target.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- Nutrition and hydration assessments were not always completed. We found gaps in feeding charts and the frequency of patient assessment reviews.
- The pain tool, used by the service to assess and manage pain, was not consistently completed and reviewed.
- Staff did not receive regular clinical supervision.
- The service were not meeting the trust target of 85% for completion of staff appraisals.
- Medical staff were not compliant with the trust target for mandatory training in Deprivation of Liberty Safeguards.

However:

- The neonatal unit held a weekly term admissions meeting to consider any changes that could be implemented to avoid future admissions.
- We saw evidence of good multidisciplinary working throughout all areas of the children and young people's service. Psychosocial and complex case meetings discussed the social and psychological wellbeing of patients.
- Staff were meeting the trust target for mandatory training in Mental Capacity Act level 1 and 2.

Is the service caring?

Good  

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

- We observed compassionate care being provided across all areas of the children and young people's service by nursing and medical staff.
- All children and their carers said that staff were kind and friendly, making the hospital a welcoming place.
- Children and their carers felt fully involved in their care and treatment. Doctors and nurses explained procedures in a relaxed and child friendly manner.
- A play worker spent time with children, and helped to reduce their anxieties before and during procedures.
- Staff provided a sensitive and compassionate service to patients receiving palliative care and at the end of life.

Is the service responsive?

Requires improvement 

Our rating of responsive went down. We rated it as requires improvement because:

- During the last inspection, we found that improvements were needed in the children's post-operative environment. During this inspection, we found that some improvements had been made. However, children were still able to see adults being received in to the theatre recovery area. Due to the central location of the recovery bay, children would be subjected to hostile sights and sounds. Managers told us they minimised the time children spent within the area by scheduling them for surgery first.
- The children and young people's service did not have a nursing lead for inpatients with a learning disability or mental health concerns at Northwick Park. Advice was sought from the Children and Adolescent Mental Health Services Monday to Friday, with on call support provided at night or weekend.
- A generic care plan was used for children on Jack's Place, and we saw limited examples of individual needs being recorded on patient records.
- The service did not always provide a smooth and timely transition for patients moving between children and adult services. The trust did not have a transition policy and staff felt that guidelines required clarity.
- Bed space capacity during the winter months was not meeting the increasing demand, particularly for patients with higher and more complex needs. The inpatient ward was providing high dependency care, although this was not yet funded and there was no designated area.

- A breakdown in communication with some surgical divisions had led to patients arriving on the day, without surgical beds being available.
- The service were not always responding to complaints within the trust target timeframe.

However:

- The facilities to stay overnight and make refreshments met the needs of parents and carers.
- The inpatient ward and outpatient's department had been refurbished to encourage a child friendly environment, with a large variety of play equipment available on Jack's Place.
- Transitional care was provided on the neonatal ward, enabling mothers to stay with their baby whilst receiving hospital care, and preparing for discharge.
- The service had responded to feedback in relation to the food offered. Patients and carers told us that the food options were good, with arrangements made for specific dietary requirements.
- Interpreting services were arranged for patients whose first language was not English.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- At the time of inspection the service did not have its own board, although we were told this was in the developmental stages.
- Senior leaders of the trust were rarely seen on the children and young people's wards. Medical staff told us there was no forum for them to raise ideas or concerns with the senior leadership team.
- Audits were regularly undertaken within the service to check that guidelines were being followed. However, robust action plans were not always put in to place when gaps were identified.
- The service was developing the strategy to enable an integrated service between the acute and community setting. However, at the time of our inspection all patient records were paper based, and therefore did not enable staff to access information recorded within the community setting.
- The electronic system upon which mandatory training was recorded was not always accurate and up to date.
- The service did not have a forum for children and young people, and their carers, to provide feedback about the care and treatment received at the hospital.
- Most staff within the children and young people's service said that communication could be improved. In particular, staff said ward meetings did not always go ahead. Emails with a brief summary were sent out to staff who missed meetings.

However:

- Localised managers were visible on the wards on a daily basis. Staff spoke highly of the matrons and ward managers, saying they were approachable and had an open door policy.
- Staff spoke of a friendly working environment, where staff worked together to reach the same goal, despite sometimes challenging circumstances.

- The service had won a national patient experience network award for its' use of technology and actively engaging with adolescent users of the diabetes services. This had led to a reduction in patient non-attendance at the diabetes clinics.

Areas for improvement

Actions the provider MUST take to improve:

- The trust must ensure robust safeguarding systems and procedures are put in to place to ensure children are protected from harm and abuse.
- The trust must ensure that nutrition and hydration assessments are routinely carried out and consistently reviewed.

Actions the provider SHOULD take to improve:

- The trust should ensure that nursing and medical staff are compliant with mandatory training.
- The trust should update the safeguarding training strategy and ensure that delivery of children's safeguarding level 3 is compliant with the intercollegiate document.
- The trust should ensure that all risk assessments including pain scores and pressure ulcer assessments are completed and reviewed in a timely manner.
- The trust should take steps to improve communication throughout the children's and young people's service, particularly feedback regarding incidents and lessons learnt.
- The trust should review the provision for children with a learning disability and mental health concern to ensure that timely support is available at all times.
- The trust should ensure robust processes are in place for the transition between children and adult services.

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Key facts and figures

London North West University Healthcare NHS Trust is one of the largest integrated care trusts in the country, bringing together hospitals and community services across Brent, Ealing and Harrow. The trust employs more than 9,000 clinical and support staff and serves a diverse population of approximately one million people. The trust operates at three acute sites: Northwick Park Hospital, Ealing hospital and Central Middlesex hospital.

The trust has 1,260 beds including 66 children's beds and neonatal care cots, 68 maternity beds, 33 critical care beds.

Ealing Hospital serves an ethnically diverse population mainly in the London Borough of Ealing.

Ealing hospital provides the following services:

- Urgent and emergency care
- Medical care (including older peoples care)
- Surgery
- Outpatients and diagnostics
- Critical care
- End of life care
- Children's and young people services.

Summary of services at Ealing Hospital

Requires improvement ➔➔

Our rating of services stayed the same. We rated it them as requires improvement because:

- Overall, we rated caring as good. Effective, responsive and well-led were rated as requires improvement. Safe was rated as inadequate.
- Urgent and emergency services went down from requires improvement to inadequate.
- We rated well-led in urgent and emergency care as inadequate.
- Safe was rated as inadequate in urgent and emergency services and medical care.

Summary of findings

- Caring was rated as requires improvement in medical care.

Urgent and emergency services

Inadequate 

Key facts and figures

The emergency department at Ealing hospital is located alongside an Urgent Care Centre (UCC). The UCC at Ealing hospital is not managed or staffed by staff from London North West Healthcare Trust and was not inspected as part of this inspection. However, we looked at how the Ealing Hospital emergency department and the UCC worked together in determining whether patients would be seen in the emergency department or in the UCC. The role of the UCC is to manage people with minor illnesses to avoid inappropriate pressure on the emergency department.

The emergency department at Ealing is made up of separate areas including majors, resuscitation, and the clinical decision unit. The majors area is referred to as the 'trolleys' area and the terms are used interchangeably.

When we inspected the service in 2015, the emergency department had a separate paediatric area where children were seen. However, at the time of this inspection Ealing emergency department no longer had a paediatric section.

We also inspected the Older People Rapid Assessment Clinic (OPRAC) which is located on the hospital site but separate from the emergency department.

We carried out our announced inspection at Ealing emergency department from 5 to 7 June 2018.We spoke with 56 Members of staff including nurses, consultants, junior doctors, allied health professionals, support staff and senior management. We also spoke with 10 patients and six relatives and reviewed 30 sets of patient records. We observed patient care and treatment and used information provided by the organisation prior to, during, and after the inspection in making a decision about the emergency service at Ealing hospital.

Summary of this service

Our rating of this service went down. We rated it it as inadequate because:

- Although this emergency department became an adult only emergency department with no paediatric section in 2016, staff were still treating children as opposed to stabilising them and transferring to a paediatric emergency department.
- Following the inspection, the trust gave us different sets of figures for the number of children who had been treated in the department. Eventually we were given a total of 61 children out of 181 under the age of 16. In the case of six of these (one in ten of the total) the correct treatment pathway had not been followed. Following the inspection the trust completed a root cause analysis relating to these cases.
- Though most were trained in immediate life support (ILS), only one nurse in the emergency department was trained in advanced life support (ALS).
- Staff treated level two patients in the chest pain area of the clinical decision unit (CDU) without an assessment of the appropriate nurse to patient ratio. Level two patients are patients requiring higher levels of nursing care and detailed observation or intervention.
- Mandatory training completion rates were low. The trust's 85% target was not met by medical staff in all nine mandatory modules and met by nursing staff in only three of the nine mandatory training modules.
- The department still faced significant issues with ambulance turnaround which led to high numbers of black breaches. A "black breach" occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

Urgent and emergency services

- The emergency department did not have an observations policy in relation to patients awaiting assessment under the Mental Health Act 1983.
- The emergency department had two dedicated mental health assessment rooms. At our last inspection we identified some ligature points. At this inspection we found that improvements had been made and both rooms were anti-ligature. However, we found that the new anti-ligature handles could make the doors difficult to open from the inside. We raised this issue with the trust during the inspection and the trust addressed it.
- There were high medical and nursing vacancy rates with no real improvement from the time of our previous inspection in 2015.
- The emergency department performed poorly in most of the Royal College of Emergency Medicine (RCEM) audits.
- From April 2017 to January 2018, 60% of required staff within the emergency department received an appraisal compared to the trust target of 85%.
- There was poor mental capacity training in relation to medical staff. Only 27% of medical staff had completed this training.
- The RCEM recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust consistently failed to meet the standard, and consistently performed worse than the England average from March 2017 to February 2018.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. The trust consistently failed to meet this standard, and performed worse than the England average in all but one month between April 2017 to March 2018.
- The trust responded to only 46% of complaints within the target period of 40 working days. The trust's target is that 80% of complaints should be responded to within 40 working days.
- The emergency department experienced a lack of capacity which affected patients' access to and flow within the department. We found that some patients were moved from the emergency department and nursed in corridors while waiting for a bed to become available on the inpatient wards.
- There was no clear strategy for the department and staff were still unclear about the future of the department.
- Staff reported that there was a lack of divisional and senior trust leadership presence and leadership in relation to the emergency department.
- The local and divisional leadership had not identified the risk relating to children attending this emergency department which did not have a paediatric provision.
- There was a lack of oversight and a lack of clear processes and procedures in relation to the management of children presenting to this emergency department. Frontline staff were unable to articulate the correct treatment pathway for children who presented at the emergency department.
- Most staff expressed that the views of Ealing emergency department and the views of the emergency and ambulatory care division at Ealing were not listened to or prioritised with those of the Northwick Park being prioritised.
- Staff described the relationship between the local leadership team in the emergency department and the site management team as 'difficult'. This was particularly related to the management of capacity in the department.

However:

Urgent and emergency services

- The service had systems and processes to keep people safe and safeguard them from abuse and staff understood these processes. Staff had training on safeguarding patients and worked well with external agencies.
- We found there was an embedded culture of incident reporting and learning from incidents.
- The service had continued to provide care and treatment based on national guidance and evidence of its effectiveness.
- There had been an improvement in relation to nursing staff training in mental capacity.
- There was an improvement in relation to how the service ensured staff competencies. A practice development nurse (PDN) in the department worked effectively with staff in relation to their competencies.
- Similar to the previous inspection we found effective multidisciplinary working amongst staff including with the psychiatric liaison team.
- Patients and relatives spoke positively about their experience of care in the emergency department. Patients and those close to them reported they had been involved in decisions about their care and treatment.
- Staff cared for patients with compassion and treated patients and their families/carers with dignity, kindness and respect.
- The values of the trust were embedded and staff at all levels were able to tell us what the trust values were and how they applied to their roles.
- Staff said they were supported, valued and respected by the local leadership within the emergency department.

Is the service safe?

Inadequate

Our rating of safe went down. We rated it as inadequate because:

- In 2016, this emergency department at Ealing became an adult only emergency department with no paediatric section. However, we found that staff were still treating children as opposed to stabilising them and transferring to a paediatric emergency department.
- Following the inspection, the trust gave us different sets of figures for the number of children who had been treated in the department. Eventually we were given a total of 61 children out of 181 under the age of 16. In the case of six of these (one in ten of the total) the correct treatment pathway had not been followed. The trust is yet to complete the root cause analysis in relation to these six children.
- Only one nurse in the emergency department was trained in advanced life support (ALS).
- Staff treated level two patients in the chest pain area of the clinical decision unit (CDU) without an assessment of the appropriate nurse to patient ratio. Level two patients are patients requiring higher levels of nursing care and detailed observation or intervention.
- The two mental health assessment rooms in the emergency department could be locked from the inside and could not be opened from the outside once locked. This meant there was a risk that a patient awaiting a mental health assessment could potentially lock themselves in the assessment room. We raised this issue with the trust during the inspection and the trust addressed it.

Urgent and emergency services

- Since our previous inspection in 2015 there had been an increase in the number of monitoring equipment in the department. However, staff reported that monitoring equipment was still insufficient because it was almost always in use by level two patients in the chest pain area of the CDU.
- The department still faced significant issues with ambulance turnaround which led to high numbers of black breaches. A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.
- Not all staff in the emergency department knew where the emergency paediatric medicines were stored. Some said it was in a locked cupboard and others said it was in a grab bag. This meant there was a risk of staff not accessing these medicines quickly enough in an emergency.
- Mandatory training completion rates were low. The trust’s 85% target was not met by medical staff in all nine mandatory modules and met by nursing staff in only three of the nine mandatory training modules by nursing staff.
- There had been no improvement in relation to nursing and medical vacancies in the emergency department and staffing was still a significant concern. The department had a 59% vacancy rate for newly qualified or the lowest nursing band (band five) as at June 2018 and a 28% medical vacancy rate from January 2017 to December 2017.

However:

- The service had systems and processes to keep people safe and safeguard them from abuse and staff understood these processes. Staff had training on safeguarding patients and worked well with external agencies.
- Since our previous inspection in 2015, there had been an improvement in relation to the completion of patient records, for example, in relation to the recording of pressure ulcer assessments.
- There had been an improvement in relation to a culture of learning from incidents. At our previous inspection we found that learning from incidents was not embedded. This time we found a culture of incident reporting and learning from incidents.

Is the service effective?

Requires improvement  

Our rating of effective stayed the same. We rated it as requires improvement because:

- Appraisal rates for staff in the emergency department were lower than the trust target of 85% and lower compared to the time of our previous inspection. From April 2017 to January 2018 only 60% of required staff had received an appraisal.
- Although the emergency department was in the best 25% of UK emergency departments for six of the seven standards in the 2016/17 moderate and acute severe asthma report, it failed to meet any of the standards.
- As was the case at the previous inspection, the department failed to meet any of the standards relating to the consultant sign-off audit, and was in the worst 25% of UK emergency departments for two standards and in the middle 50% of UK emergency departments for the remaining two standards for the 2016/17 audit.
- The emergency department performed poorly in relation to the 2015/16 and 2016/17 procedural sedation in adults audits and the 2015/16 venous thrombo-embolism risk in lower limb immobilisation in plaster cast audit where it failed to meet any of the standards.
- For the 2015/16 procedural sedation in adults audit the department was in the worst 25% of emergency departments in England in three standards. The remaining four standards were all between the upper and lower England quartiles.

- In the 2015/16 venous thrombo-embolism risk in lower limb immobilisation in plaster cast audit the department was in the bottom 25% of emergency departments in England quartile for both standards.
- There had been no improvement in relation to mental capacity training for medical staff. Following our previous inspection in 2015 we reported that staff in the emergency department had not received this training. During this inspection we found that only 27% of medical staff had completed mental capacity training.
- Although staff recorded patients' pain scores consistently and provided pain relief they did not always go back to reassess pain or check if the patients' pain had been relieved following pain medication.
- As was the case at the previous inspection, the emergency department did not have a dedicated kitchen and meals were provided from other wards/departments within the hospital.

However:

- The service had continued to provide care and treatment based on national guidance and evidence of its effectiveness.
- There had been an improvement in relation to nursing staff mental capacity training. At our previous inspection we reported that staff had not received this training. During this inspection 91% of nursing staff had been trained.
- There had been an improvement in relation to the unplanned re-attendance rate within seven days. Following our previous inspection in 2015 we reported that the rate was consistently higher than the national target of 5%. At the time the department's rate was 13%. In the 12 months prior to our inspection the rate was 0.7%.
- There had been an improvement in relation to how the service ensured staff competencies. A practice development nurse based in the department worked effectively with staff in relation to their competencies and we saw evidence of the training they provided to staff.
- Similar to the previous inspection, we found effective multidisciplinary working amongst staff including with the psychiatric liaison team.

Is the service caring?

Good 

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

- As was the case at the previous inspection in 2015, patients and relatives spoke positively about their experience of care in the emergency department. Patients and those close to them also reported that they had been involved in decisions about their care and treatment.
- Staff cared for patients with compassion and treated patients and their families/carers with dignity, kindness and respect. We observed positive and compassionate interactions between staff and patients.
- The Friends and Family Test is a measure of patient satisfaction with a service. Data received as part of this inspection showed that most patients would recommend the service to others.
- Patients told us that staff provided them with emotional support to when they felt distressed. We saw examples of staff reassuring patients and their relatives who were concerned about their treatment.

However:

- In the majors and trolleys section of the emergency department, cubicles were divided using curtains which meant that conversations between health professionals and patients could be heard by others.

Urgent and emergency services

Is the service responsive?

Requires improvement  

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

- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust consistently failed to meet the standard, and consistently performed worse than the England average, from March 2017 to February 2018. However there was some improvement shown from April 2018 to June 2018 where the trust met the standard.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. There had been no improvement in this standard from the time of the last inspection in 2015.From April 2017 to March 2018 the trust consistently failed to meet the standard, and performed worse than the England average in all but one month.
- The trust took an average of 41.1 working days (mean) to investigate and close complaints and responded to only 46% of complaints within the target period of 40 working days. This is not in line with their complaints policy, which states that 80% of complaints should be responded to within 40 working days. The Emergency & Ambulatory Care division response rate was better than the trust average at 64% for April, 81% for May and 78% for June.
- The emergency department inappropriately used the clinical decision unit (CDU) for the admission of patients who should have been inpatients on medical wards and this meant there was a lack of beds for patients coming in to the emergency department.
- The vending machines in the reception area were empty which meant patients coming into the emergency department could not easily access food and drink.
- The emergency department experienced a lack of capacity which affected patients' access to and flow within the department. We found that staff patients were moved from the emergency department and nursed in corridors while waiting for a bed to become available on the inpatient wards.

However:

- Overall, the service was coordinated to take account of the needs of different people. Staff had received training in relation to mental health, dementia and learning disabilities.
- Staff had access to translators when needed giving patients the opportunity to make decisions about their care, and day-to-day tasks.
- There were two rooms in the emergency department which were specifically used to assess patients under the Mental Health Act 1983.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate because:

- At the previous inspection there was no clear strategy for the emergency department. At this inspection, we found there was still no clear strategy for the department and staff were still unclear about the future of the department. The strategy document presented following the inspection was a in draft form.

- Staff had not been consulted in relation to the future plans for the emergency department which had been set out in the draft strategy mentioned above.
- Although we received consistent feedback from staff that leadership within the department was supportive, visible and approachable there was also consistent feedback that there was a lack of divisional and senior trust leadership presence and leadership in relation to the emergency department.
- There was a lack of oversight and a lack of clear processes and procedures in relation to the management of children presenting to this emergency department.
- There was confusion over the provision of treatment for children in the emergency department even though it was clear that the Clinical Commissioning Group (CCG) had decommissioned the treatment of children except for stabilisation. During our inspection, frontline staff were unable to articulate the correct treatment pathway for children who presented at the emergency department.
- Most staff, including staff in senior roles within the emergency department (both nursing and medical) expressed that the views of Ealing emergency department and the views of the emergency and ambulatory care division at Ealing were not listened to or prioritised with those of the Northwick park being prioritised.
- Staff described the relationship between the local leadership team in the emergency department and the site management team as 'difficult'. This was particularly related to the management of capacity in the department.

However:

- The values of the trust were embedded and staff at all levels were able to tell us what the trust values were and how they applied to their roles.
- There was alignment between what the local leadership and divisional leadership said the risks within the emergency department were.
- Quality and safety received sufficient coverage in board meetings, and in other relevant meetings below board level as evidenced by the meeting minutes we saw during and following the inspection.
- Staff said they were supported, valued and respected by the local leadership within the emergency department.

Areas for improvement

Action the trust MUST take to improve:

- The trust must have a clear policy on the management of children presenting to the Ealing emergency department.

Action the trust SHOULD take to improve:

- Ensure there is a clear policy on the location of emergency paediatric medicines in the emergency department.
- Ensure staff meet the trust targets for mandatory training.
- Ensure that the service meets the target for staff appraisals.
- Ensure that medical staff complete mental capacity training.
- Review the arrangements for patients being admitted into the chest pain area in the clinical decision unit (CDU).
- Address nursing and medical vacancies in the emergency department.

Medical care (including older people's care)

Requires improvement ➔➔

Key facts and figures

Medical services involve assessment, diagnosis and treatment of adults by means of medical interventions rather than surgery.

The medical care service at Ealing Hospital provides care and treatment for care of the elderly, cardiology, respiratory medicine, gastroenterology, infectious diseases, clinical oncology, and general medicine. There are 320 medical inpatient beds located across the wards.

Ealing Hospital has 304 medical inpatient beds located across 13 wards and units. The trust had 74,005 medical admissions from January to December 2017. Emergency admissions accounted for 26,423 (35.7%), 1,175 (1.6%) were elective, and the remaining 46,407 (62.7%) were day case.

Admissions for the top three medical specialties were General medicine (27,345 admissions), gastroenterology (26,799 admissions), and clinical haematology (6,118 admissions)

Medical care at Ealing Hospital was last inspected in October and November 2015 when it was rated good for caring, and requires improvement for safe, effective, responsive, and well led. Medical care was rated as requires improvement overall. Areas for improvement that were found during the last inspection included completing and recording assessments for nutrition and hydration, improve mandatory training levels, improve IPC practices and hand hygiene, develop individualised care plans, and ensure staff are aware of Mental Capacity and Deprivation of Liberty safeguards.

We carried out our inspection at Ealing Hospital medical wards from 5 to 7 June 2018. During our inspection we visited we visited seven wards: 4 South (Cardiology), 5 North and South (Care of the Elderly), 6 North (Gastroenterology and endocrinology), 6 South (Respiratory), 8 South (Infectious Diseases), and the Acute Medical Unit (AMU). We also visited the endoscopy unit, the ambulatory care unit, and the discharge lounge.

We spoke with 10 patients and two relatives, and reviewed 20 sets of patient records. We also spoke with 78 members of staff, including qualified and student nurses, matrons, consultants, doctors, senior managers, and support staff.

Summary of this service

Our rating of this service stayed the same. We rated it it as requires improvement because:

- Medical staff at Ealing Hospital were not meeting the trust target of 85% for any of the nine mandatory training modules. Training rates for many of the courses, including basic life support, information governance, and infection control, were between 22 and 19%.
- There were high levels of nursing vacancies across some medical wards, particularly in the Acute Medical Unit. Medical wards relied on bank and agency staff to fill shifts, and staff we spoke with stated this had an impact on the consistent delivery of care.
- Medical wards often did not have the staff to meet the recommended levels for managing patients with higher acuity, particularly high dependency patients in the cardiology coronary care unit.
- Of the 20 admissions booklet we looked at we found risk assessments were inconsistently completed or not completed at all. This was most significant for risk assessments for VTE, skin integrity, and MUST scores. We also found NEWS to be inconsistently completed, or not escalated when a NEWS score was above the threshold.

Medical care (including older people's care)

- The last inspection report included a requirement for the trust to ensure Control of Substances Hazardous to Health (COSHH) assessments were up to date and maintained. We found COSHH assessments on medical wards which were significantly out of date, and ward managers unaware if the assessment had been completed or not.
- There was a lack of adequate out of hours cover for medical wards. Junior medical staff we spoke with stated that did not feel there was sufficient support available from the on-site registrar due to their workload, particularly on nights.
- Medical staff and patients we spoke with stated that medical outliers on other wards and in other departments did not always receive a consultant ward round to the same level as patients admitted on to the appropriate medical ward. Staff stated that outliers may often be seen by junior doctors.
- Medical staff we spoke with stated that there were significant gaps in the registrars rota, which often required consultants to act down to fill. The trust fill rate for shifts as of December 2017 was 80%.
- Fridge temperature records were recorded inconsistently, and when recorded outside of normal range was not escalated.
- We found examples of medications out of date across medical wards, including CDs. There was no date checking process for medicines which were not stored in the wards' medication vending systems. Staff were routinely not recording the dates medication had been opened or expiry dates, often by several months.
- The previous report included a requirement for patients' nutrition and hydration to be monitored and fully recorded. However, in the patient admissions booklets we viewed on medical wards, we found MUST scores were completed inconsistently or not completed at all. The division carried out monthly audits on recording of nutritional screening in patient records.
- The previous report included a requirement to improve record keeping with respect to fluid balance charts. However, we fluid balance charts which were kept by the patients bed on medical wards and found they were still inconsistently completed and not updated in line with the trust policy.
- Some staff we spoke stated they did not receive training in the use of the patient admissions booklet. Senior staff we spoke with stated training had been delivered and that PDNs were available to provide support and advice in the use of the new patient record, however staff (including bank and agency) we spoke with stated the new record had been introduced without staff receiving sufficient training.
- Staff understanding of patients need for MCA and DoLS assessments was variable. Some staff were not able to demonstrate awareness of when MCA and DoLS assessments would be necessary. We also found that recording of capacity assessments and decisions on deprivation of liberty were not consistently documented appropriately.
- Most patients we spoke with stated that staff respected their privacy. However on some wards we observed patients being cared for in corridors on trolleys or on chairs, within view of the nursing stations, which may have impacted on privacy.
- On inspection we found a significant number of patients being cared for as outliers both on other medical wards, and in other areas of the hospital, particularly in surgery. Staff we spoke with stated that patients were consistently being cared for as medical outliers, and this presented challenges in providing oversight for those patients, unnecessary patient transfers between wards, and blocking beds for patients in other wards.
- Medical wards at Ealing Hospital followed the trust "+1" escalation policy. This stated that at times of high activity, an additional patient could be cared for in the corridor of the ward. Most staff we spoke with stated that this policy did not provide patients with much privacy or dignity, and patients in practice could spend long periods in corridors before being provided with a bay or receiving a discharge.

Medical care (including older people's care)

- Patient records we viewed for patients who had been identified with dementia did not have the care pathway document completed, or only partially completed. This meant that the individual needs of patients were not being adequately recorded, which may have impacted on the availability of enhanced care.
- Staff we spoke with across medical wards were unsure of the future development plans or the vision for the division at Ealing Hospital. Staff stated that the communication from the trust regarding future plans was somewhat unclear, and that this created some anxiety for the staff. Staff we spoke with also stated they did not feel they had been consulted on the direction of the clinical strategy.
- We found clinical governance at a ward level was inconsistent, meaning some risks we found were not being picked up and reporting them (such as inconsistent record keeping) and staff were not always informed of how issues were being addressed.
- Although medical wards had a risk register in place, the register did not reflect some of the concerns we identified on inspection. This included inconsistent completion of patient risk assessments, management of medical outliers on non-medical wards, and medical staffing mix.
- Staff we spoke on medical wards stated there were not opportunities for engagement at Ealing Hospital, and they did not feel represented or consulted on the future direction of the hospital. Staff from medical wards consistently stated that the lack of engagement was impacting on morale for staff.

However

- Incidents were reported on and discussed through the divisional governance structure, and from this actions will be identified to minimise the risk of repeat occurrences. Staff stated there was a positive culture in relation to reporting and learning from incidents.
- Trainee doctors were positive about the level of training they had access to. Junior doctors stated there was good access to training opportunities, and were particularly positive about the availability of consultants to provide advice and support.
- Staff on the wards we visited demonstrated an awareness of the trust's safeguarding processes, and could explain what signs they may need to look for to identify potential safeguarding concerns. Staff also knew how to contact the safeguarding team for advice and guidance when required.
- The last inspection report included a requirement for medical wards to improve cleanliness of equipment and fixtures at Ealing Hospital. On this inspection, the environment on the medical wards and areas we visited was generally clean and organised.
- We observed care on medical wards during our visit and found it was delivered in line with evidence-based guidance, and was supported by local guidelines and standard operating procedures.
- Throughout our inspection we saw consistent evidence of multidisciplinary team (MDT) working across all disciples and wards. Staff we spoke with were positive about the relationship between different disciplines on medical wards, and stated they were supported by colleagues when they needed specialist support and advice.
- The trust had three Practice Development Nurses (PDNs) who were available to provide advice and support on available courses and education opportunities, as well as deliver training. Staff we spoke with stated the PDNs were easy to access and supportive.
- Policies and procedures we viewed were reviewed regularly. Any of the policies we reviewed on inspection were in date, available through the staff intranet, and easy to read for staff. Divisional and speciality leads reviewed policies and updated ones that required review or needed to reflect new guidance or legislation.

Medical care (including older people's care)

- Across medical wards we observed generally positive interactions between patients and medical staff. Staff were supportive to patients when available, and treated them with dignity and respect. Interactions between staff and patients were friendly, and staff made time to ask if patients needed anything.
- We spoke with 10 patients during the inspection across a number of medical wards, who were generally positive about the care they received and the staff they had met.
- Most patients and relatives we spoke with felt they had been well involved in their care and their relative's care. Patients stated that with care planning included a number of clinicians input but also was patient centred and included the views of their family.
- Staff on medical wards stated they could access translation services for patients who could not speak English, and were familiar with the process of how to do so.
- Medical wards provided additional support for patients with complex needs, including those diagnosed with dementia or a learning disability.
- We saw posters and leaflets advertising the Patient Advice and Liaison Service (PALS) throughout the wards. Staff we spoke with stated they were aware of how to direct patients or visitors to the PALS team, and also stated that PALS would regularly provide advice and support to the ward.
- Staff we spoke with were positive about the divisional leadership, stating they were visible and generally accessible.
- The trust had a number of leadership development opportunities to support staff to become managers, and staff we spoke with felt encouraged by their managers to apply for promotion. The trust ran an annual leadership programme in collaboration with a connected university, as well as an aspiring ward managers programme to develop nursing staff into management.
- Medical staff we spoke with, including junior doctors, were positive about medical leadership within the division on-site, and felt the consultant body worked well together.
- The trust values (HEART) were clearly displayed on wards we visited and staff we spoke with were generally aware what HEART stood for.

Is the service safe?

Inadequate  

Our rating of safe went down. We rated it as inadequate because:

- Medical staff at Ealing Hospital were not meeting the trust target of 85% for any of the nine mandatory training modules. Training rates for many of the courses, including basic life support, information governance, and infection control, were between 22 and 19%.
- Isolation rooms did not have negative or positive air flow to control the risk of infection from patients with potentially contagious illnesses. This presented a particular risk for patients on the infectious diseases wards, where there was a possibility of cross-contamination.
- The last inspection report included a requirement for the trust to ensure Control of Substances Hazardous to Health (COSHH) assessments were up to date and maintained. We found COSHH assessments on medical wards which were significantly out of date, and ward managers unaware if the assessment had been completed or not.

Medical care (including older people's care)

- Of the 20 admissions booklet we looked at we found risk assessments were inconsistently completed or not completed at all. This was most significant for risk assessments for VTE, skin integrity, and MUST scores. We also found NEWS to be inconsistently completed, or not escalated when a NEWS score was above the threshold.
- There were high levels of nursing vacancies across some medical wards, particularly in the Acute Medical Unit. Medical wards relied on bank and agency staff to fill shifts, and staff we spoke with stated this had an impact on the consistent delivery of care.
- Medical wards often did not have the staff to meet the recommended levels for managing patients with higher acuity, particularly high dependency patients in the cardiology coronary care unit.
- There was a lack of adequate out of hours cover for medical wards. Junior medical staff we spoke with stated that did not feel there was sufficient support available from the on-site registrar due to their workload, particularly on nights.
- Medical staff and patients we spoke with stated that medical outliers on other wards and in other departments did not always receive a consultant ward round to the same level as patients admitted on to the appropriate medical ward. Staff stated that outliers may often be seen by junior doctors.
- Medical staff we spoke with stated that there were significant gaps in the registrars rota, which often required consultants to act down to fill. The trust fill rate for shifts as of December 2017 was 80%.
- The previous report identified a requirement for patient records to be secured at all service locations. However throughout medical wards we found patient records trolleys unsecured and unattended in corridors, as well computer terminals with access to discharge summaries unlocked.
- Fridge temperature records were recorded inconsistently, and when recorded outside of normal range was not escalated.
- We found examples of medications out of date across medical wards, including CDs. There was no date checking process for medicines which were not stored in the wards' medication vending systems. Staff were routinely not recording the dates medication had been opened or expiry dates, often by several months.
- We found examples of medications left unattended across medical wards. On some medical wards we found current or expired medications in drug trolleys which had not be disposed of or reported to the pharmacy team. We also found examples of saline bags and IVs left unattended in the ambulatory medical unit.

However

- Incidents were reported on and discussed through the divisional governance structure, and from this actions will be identified to minimise the risk of repeat occurrences. Staff stated there was a positive culture in relation to reporting and learning from incidents
- Trainee doctors were positive about the level of training they had access to. Junior doctors stated there was good access to training opportunities, and were particularly positive about the availability of consultants to provide advice and support.
- Staff on the wards we visited demonstrated an awareness of the trust's safeguarding processes, and could explain what signs they may need to look for to identify potential safeguarding concerns. Staff also knew how to contact the safeguarding team for advice and guidance when required.
- The last inspection report included a requirement for medical wards to improve cleanliness of equipment and fixtures at Ealing Hospital. On this inspection, the environment on the medical wards and areas we visited was generally clean and organised.

- Staff we spoke with were positive about the Critical Care Outreach Team, which was available 24 hours a day seven days a week, with two nurses on duty day and night.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- The previous report included a requirement for patients' nutrition and hydration to be monitored and fully recorded. However, in the patient admissions booklets we viewed on medical wards, we found MUST scores was completed inconsistently or not completed at all. The division carried out monthly audits on recording of nutritional screening in patient records.
- The previous report included a requirement to improve record keeping with respect to fluid balance charts. However, we fluid balance charts which were kept by the patients bed on medical wards and found they were still inconsistently completed and not updated in line with the trust policy.
- The patient admissions booklet contained a section for completion on pain and comfort. In the records we viewed we found this to be inconsistently completed or not completed. The admissions booklet suggested assessing pain by verbal and non-verbal communication, however there the scoring criteria was not clear, and what actions should be taken for each level of scoring.
- The trust completion rate for appraisals was 62%, significantly below the trust target of 85%.
- Some staff we spoke stated they did not receive training in the use of the patient admissions booklet. Senior staff we spoke with stated training had been delivered and that PDNs were available to provide support and advice in the use of the new patient record, however staff (including bank and agency) we spoke with stated the new record had been introduced without staff receiving sufficient training.
- Staff understanding of patients need for MCA and DoLS assessments was variable. Some staff were not able to demonstrate awareness of when MCA and DoLS assessments would be necessary.
- We found that recording of capacity assessments and decisions on deprivation of liberty were not consistently documented appropriately in the patient admissions booklet, and there appeared to be no area for recording consent to treatment.

However

- We observed care on medical wards during our visit and found it was delivered in line with evidence-based guidance, and was supported by local guidelines and standard operating procedures.
- Throughout our inspection we saw consistent evidence of multidisciplinary team (MDT) working across all disciples and wards. Staff we spoke with were positive about the relationship between different disciplines on medical wards, and stated they were supported by colleagues when they needed specialist support and advice.
- The trust had three Practice Development Nurses (PDNs) who were available to provide advice and support on available courses and education opportunities, as well as deliver training. PDNs also provided tailored support for nurses revalidating, student nurses and return to practice nurses. Staff we spoke with stated the PDNs were easy to access and supportive.

Medical care (including older people's care)

- Speech and language therapists (SALTs) and dieticians worked closely with nursing and medical staff in assessing and supporting patients with eating, drinking and swallowing needs. In medical records we reviewed we identified input from SALTs and dieticians. The hospital also had diabetes specialist nurses who could provide advice and support to staff and patients.
- Policies and procedures we viewed were reviewed regularly. Any of the policies we reviewed on inspection were in date, available through the staff intranet, and easy to read for staff. Divisional and speciality leads reviewed policies and updated ones that required review or needed to reflect new guidance or legislation.

Is the service caring?

Requires improvement 

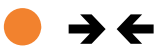
Our rating of caring went down. We rated it as requires improvement because:

- Most patients we spoke with stated that staff respected their privacy. However, on some wards we observed patients being cared for in corridors on trolleys or on chairs, within view of the nursing stations, which may have impacted on privacy.
- We observed patients being cared for on the "+1" escalation policy being referred to as "the Plus one" when their care or needs were being discussed by staff, rather than using the patient's name. This included when patients could hear the staff discussing them, which did not respect the patient's dignity. For example, on one ward were overheard a member of staff stating "The Plus one needs a cup of tea".

However:

- Across medical wards we observed generally positive interactions between patients and medical staff. Staff were supportive to patients when available, and treated them with dignity and respect. We also spoke with 10 patients during the inspection across a number of medical wards, who were generally positive about the care they received and the staff they had met.
- Most patients and relatives we spoke with felt they had been well involved in their care and their relative's care. Some medical wards ran or offered access to support groups for patients and their family members to cope with illness.

Is the service responsive?

Requires improvement 

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

- On inspection we found a significant number of patients being cared for as outliers both on other medical wards, and in other areas of the hospital, particularly in surgery. Staff we spoke with stated that patients were consistently being cared for as medical outliers, and this presented challenges in providing oversight for those patients, unnecessary patient transfers between wards, and blocking beds for patients in other wards.
- Medical wards at Ealing Hospital followed the trust "+1" escalation policy. This stated that at times of high activity, an additional patient could be cared for in the corridor of the ward. Most staff we spoke with stated that this policy did not provide patients with much privacy or dignity, and patients in practice could spend long periods in corridors before being provided with a bay or receiving a discharge.

- Patient records we viewed for patients who had been identified with dementia did not have the care pathway document completed, or only partially completed. This meant that the individual needs of patients were not being adequately recorded, which may have impacted on the availability of enhanced care.

However

- Staff on medical wards stated they could access translation services for patients who could not speak English, and were familiar with the process of how to do so. Translation services could be arranged by telephone or in person. Some staff also spoke other languages and could provide initial support to patients in translation if needed.
- Medical wards provided additional support for patients with complex needs, including those diagnosed with dementia or a learning disability.
- We saw posters and leaflets advertising the Patient Advice and Liaison Service (PALS) throughout the wards. Staff we spoke with stated they were aware of how to direct patients or visitors to the PALS team, and also stated that PALS would regularly provide advice and support to the ward.

Is the service well-led?

Requires improvement 

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

- Staff we spoke with across medical wards were unsure of the future development plans or the vision for the division at Ealing Hospital. Staff stated that the communication from the trust regarding future plans was somewhat unclear, and that this created some anxiety for the staff. Staff we spoke with also stated they did not feel they had been consulted on the direction of the clinical strategy.
- Staff we spoke with were unsure about future of medical wards at Ealing Hospital, and felt that this was having an impact on morale at the trust. Many staff they did not feel valued by the trust and that Ealing Hospital was "the poorer relation" compared to Northwick Park Hospital. Staff also stated they did not have much engagement with the other hospital sites that were part of the trust.
- Some staff we spoke with felt that trust-wide leadership was not visible on the Ealing site, and they felt they were not understanding of the concerns of staff regarding the future of the hospital site. Staff we spoke to were not always capable of naming the executive leadership.
- We found clinical governance at a ward level was inconsistent, meaning some risks we found were not being picked up and reporting them (such as inconsistent record keeping) and staff were not always informed of how issues were being addressed.
- Although medical wards had a risk register in place, the register did not reflect some of the concerns we identified on inspection. This included inconsistent completion of patient risk assessments, management of medical outliers on non-medical wards, and medical staffing mix.
- Staff we spoke on medical wards stated there were not opportunities for engagement at Ealing Hospital, and they did not feel represented or consulted on the future direction of the hospital. Staff from medical wards consistently stated that the lack of engagement was impacting on morale for staff.
- Medical staff stated that patient pathways and the delivery of services were redesigned without consulting the medical workforce, which meant that changes did not always include local knowledge on what worked well and what could be improved.

However

- Staff we spoke with were positive about the divisional leadership, stating they were visible and generally accessible.
- The trust had a number of leadership development opportunities to support staff to become managers, and staff we spoke with felt encouraged by their managers to apply for promotion. The trust ran an annual leadership programme in collaboration with a connected university, as well as an aspiring ward managers programme to develop nursing staff into management.
- Medical staff we spoke with, including junior doctors, were positive about medical leadership within the division on-site, and felt the consultant body worked well together.
- The trust values (HEART) were clearly displayed on wards we visited and staff we spoke with were generally aware what HEART stood for.

Areas for improvement

Action the trust MUST take to improve:

- The service must ensure safe levels of staff to ensure the provision of safe care and treatment, including out of hours arrangements for medical staff.
- The service must ensure there is consistency in relation to document completion across the wards in particular, risk assessments, fluid balance charts, and nutrition and hydration assessments.
- The trust must ensure that medicines management on medical wards is improved.
- The service must ensure the secure storage of all patient records at all service locations.
- The service must ensure mandatory training for medical and nursing staff meets the trust target of 85%.
- The service must ensure medical staff understand their roles and responsibilities in relation to the Mental Capacity Act 2005, and that MCA and DoLS assessments are appropriately completed and recorded.
- The service must ensure COSHH assessments and arrangements are up to date and maintained.
- The service must improve ventilation in the decontamination area of the endoscopy department at Ealing Hospital.

Action the trust SHOULD take to improve:

- The service should ensure that medical patients admitted on other wards receive a consultant ward round in line with the trust's policies for medical patients.
- The service should ensure that high dependency patients are provided with appropriate staff in line with national guidance.
- The service should ensure that staff are adequately trained in the appropriate completion of the patient records booklet.
- The service should ensure that clinical governance processes are applied consistently across wards.
- The service should ensure that staff receive an appraisal at least annually.
- The service should ensure that medical consultants are provided with clear job plans which are reviewed annually.

Surgery

Requires improvement 

Key facts and figures

The surgery department at Ealing Hospital provides elective and emergency surgery to the local population. Surgical specialties at the hospital include breast, ear nose and throat (ENT), maxillofacial and oral surgery, general surgery, urology, vascular surgery and trauma and orthopaedics.

The hospital had 7039 surgical admissions between June 2017 and May 2018. Emergency admissions accounted for 46.13%, 44.92% were day cases and 8.65% were elective.

The service consists of three wards, including; Ward 7 South, a 34 bedded trauma and orthopaedic ward; Ward 7 North, a 30 bedded general surgery ward; and Brunel day surgery ward (or Ward 3 North) which has 22 beds. There are five operating theatres and a six-bedded recovery unit.

We visited all wards, theatres and pre-assessment unit during our inspection from 5 June 2018 to 7 June 2018. We spoke to 46 staff including doctors across various grades, nurses, operating department practitioners, healthcare assistants and allied professionals. We reviewed 11 patient records and medication charts, and spoke to nine patients and their relatives. We made observations of the environment, staff interactions and checked various items of

Summary of this service

Our rating of this service stayed the same. We rated it it as requires improvement because:

- Many problems we found during previous inspections still existed. The recovery area was not able to cope with the level of activity. Referral to treatment times were not being met for some surgical specialities. Theatres were not always effectively utilised and operating sessions started and finished later than planned.
- There was a high vacancy rate for orthopaedic staff and low night shift fill rate on the orthopaedic ward. There was high reliance on agency staff to cover overnight shifts on the recovery unit and day surgery ward.
- The service did not comply with the principles outlined in the National Enquiry into Patient Outcome and Death (NCEPOD) requiring a dedicated theatre list for emergencies.
- Audit results reflected mixed patient outcomes for hip fracture patients and those having an emergency laparotomy.
- The trust performance for cancelled operations was worse than the England average.
- There was no clear vision or strategy for surgical services and staff did not feel supported by the divisional leadership team.
- The management team had oversight of the risks within the service and mitigating plans were in place. However, controls in place were insufficient to manage capacity and flow within surgical services.

However:

- The results of investigations into incidents were discussed in departmental and governance meetings and action was taken to follow up on the results of investigations.
- NEWS scores were used to safely monitor deteriorating patients.

Surgery

- Feedback for the services inspected were mostly positive. Staff respected confidentiality, dignity and privacy of patients.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- There was low mandatory training completion rates for medical staff as they failed to meet the trust target for any of 11 training modules. There was less than 40% compliance in half of the modules with 29% compliance rate for resuscitation training.
- We witnessed three occasions where medication was pre-prepared in anaesthetic rooms.
- There was a high vacancy rate for orthopaedics and consultants reported difficulty with filling posts for anaesthetics. In addition, there was a high turnover rate for medical staff at Ealing Hospital.
- There had been an acute shortage of staff on orthopaedic wards with a vacancy rate of 21% and night shift fill rate of 69% in the last one year.
- There was high reliance on agency staff to cover overnight shifts on the recovery unit and day surgery ward.

However:

- Patient records were comprehensive and appropriate risk assessments were completed.
- The environment was visible clean and we observed staff complied with infection prevention and control guidelines.
- Staff followed protocols for the five steps to safer surgery.
- Staff used NEWS scores to safely monitor deteriorating patients.
- Staff knew how to report incidents and confirmed learning from incidents were shared across the service.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- The service did not comply with the principles outlined in the National Enquiry into Patient Outcome and Death (NCEPOD) classifications around access to emergency theatres.
- The service participated in national audits, which meant its services could be benchmarked against other trusts. Patient outcome results were mixed when compared with England averages. The hospital performed worse than national averages and did not meet aspirational standards in the 2017 national hip fracture database.
- The National Emergency Laparotomy Audit result indicated there were insufficient cases submitted to calculate outcomes for some of the metrics. The hospital received a red rating for case ascertainment.
- Medical staff demonstrated low levels of completion of Mental Capacity Act (2005) training and did not meet the trust target of 85%.

Surgery

- Although policies and procedures were up to date and in line with best practice, staff did not always access the most up to date policies. Most of the printed-paper copies we found on the day surgery ward were out of date.

However:

- Patients were cared for by appropriately qualified staff. Nurses had gone through an induction and achieved specific competencies before being able to care for patients independently. Medical staff received regular training as well as support from consultants.
- Patients' pain were well managed with pain relief provided when necessary. Nutrition assessments were generally completed.
- The surgical team provided a seven day service and patients were empowered to manage their own health.

Is the service caring?

Good  

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

- Staff provided a caring, kind and compassionate service, which involved patients in their care and we received numerous positive comments from children and their families.
- Observations of care showed staff maintained patients' privacy and dignity on most wards visited, and patients and their families were involved in their care.
- Staff provided emotional support to patients and patients were able to access the hospital multi-faith chaplaincy services, when required.

However:

- Patients were often cared for in escalation areas, which had the potential to compromise the privacy of patients.

Is the service responsive?

Requires improvement  

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

- Medical outliers on surgical wards impacted on patient flow within surgical services. Patients stayed overnight on the recovery unit and inpatients were cared for on the day surgery ward due to lack of beds.
- There were several incidents of mixed sex breaches reported on the recovery unit.
- Referral to treatment times were not being met for some surgical specialities such as general surgery, colorectal surgery, oral surgery and ear nose and throat.
- Theatres were not always effectively utilised and operating sessions started and finished later than planned
- The trust performance for cancelled operations was worse than the England average.

However:

- Staff had access to translators when needed giving patients the opportunity to make decisions about their care, and day-to-day tasks.

- Individual care needs of patients were fully considered and acted on by staff. Arrangements were provided to support people with disabilities and cognitive impairments, such as dementia.
- The average length of stay was better than the England average.

Is the service well-led?

Requires improvement 

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

- At the previous inspection, we found there was no clear strategy for the service. At this inspection, we found there was still no overall strategy for the service.
- We received mixed feedback about the leadership of the unit. Whilst it was clear that staff felt supported by senior staff on site, senior surgical staff expressed lack of support from divisional leadership.
- Senior staff were not involved in the trusts' redesign of services at Ealing Hospital and these impacted on the morale of consultants in the hospital.
- The management team had oversight of most risks within the service and mitigating plans were in place. However, low completion rates for mandatory training for medical staff was not highlighted as a risk on the risk register. In addition, controls in place were insufficient to manage capacity and flow within surgical services.

However:

- There was a robust governance structure in place and feedback from governance meetings were disseminated to staff.
- The service engaged patients through surveys and feedback forms.

Areas for improvement

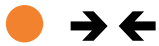
Action the trust MUST take to improve:

- Ensure patients are cared for in areas that are appropriate, meet all of their needs and have sufficient space to accommodate the potential number of people using the service at any one time.
- Ensure proper and safe management of medicines. This includes avoiding practices that compromise safe medicines management including the use of pre-prepared medication in theatres.
- Ensure there are sufficient staffing levels on orthopaedic wards.
- Work to improve access and flow within surgical services
- Work to improve mandatory training completion rates for medical staff
- Ensure staff on the Ealing site are engaged in planning and delivery of services
- Improve theatre utilisation and efficiencies related to start and finish times
- Improve referral to treatment times in surgery

Action the trust SHOULD take to improve:

- Work to improve hand hygiene compliance on Ward 7 North.

Services for children and young people

Requires improvement 

Key facts and figures

Children and young people's services are located on the 10th floor of Ealing Hospital. The children's outpatients unit and nurse led day care unit are both located in the former inpatients ward which was reconfigured in 2016 to accommodate a change in service provision. The service provides care for children 0-16 years of age but also delivers transition clinics to young people aged 16 -18 moving into adult services. The service cares for children and young people primarily in the borough of Ealing. The community children's nursing team and continuing care team are also based on the same floor.

The day care and outpatients unit at Ealing Hospital delivers a limited range of children's services and is open from 8.30am to 5.30pm Monday to Friday. The children's outpatients service provides a range of clinics including transition clinics which are clinics to support young people moving into the care of adult services, haematology, diabetes, epilepsy, general paediatrics, allergy, infectious diseases, endocrinology and urology.

The day care service consists of four bed/cot spaces and provides procedures such as blood tests, blood transfusions, intravenous infusion such as antibiotics, MRI scans under oral sedation and allergy testing.

Data provided by the trust indicated that from April 2017 to March 2018, there were a total of 16,535 outpatient attendances by children and young people under the age of 17 years at Ealing Hospital. Of these, 9,378 attendances were in paediatric specialties and the remaining 7,157 were in other specialties. In the same period there were 932 paediatric day cases at Ealing Hospital.

We visited children and young people's services over three days during our announced inspection on the 5 – 7 June 2018. We visited the paediatric outpatients unit, paediatric day care and inspected areas of adult outpatients where children would be seen.

We reviewed 10 patient care records and observed care provided. We spoke with nine parents and 17 members of staff including nurses, nurse specialists, paediatricians, a healthcare assistant and administrative staff. We also reviewed the trust's performance data and looked at trust policies for paediatrics.

Summary of this service

Our rating of this service stayed the same. We rated it it as requires improvement because:

- Mandatory training rates for medical staff were low including for safeguarding level 3 training.
- Staffing remained a challenge for the service. There were significant vacancies in the community children's nursing team and the staffing establishment was not sufficient for the level of staffing required on the children's outpatients and day care unit.
- There was no protocol or standard operating procedure available for staff to follow if a child or young person became unwell on the outpatients and day care unit.
- The Women and Children's division still did not have oversight of young people admitted to adult wards at Ealing Hospital. There was still no flagging system to identify young people who had been admitted to adult wards.
- Staff we spoke with felt learning was not shared effectively however the trust told us there were cross site governance meetings where staff could attend where learning was shared.

Services for children and young people

- Not all of the risks we identified at the Ealing Hospital site were on the risk register.
- Staff on the children's outpatients and day care unit did not receive clinical or safeguarding supervision.
- Nursing staff had not received training in the recognition and management of children with sepsis.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. However, some clinical guidelines had not been reviewed in line with trust timescales.
- There was no longer a play specialist team at the hospital. A play specialist was being recruited but the post was to be shared with the other hospital site.
- The amount of time managers dedicated to the children's services at Ealing Hospital remained very limited.
- Staff still felt unsettled and uncertain about the future provision of children's services at Ealing hospital.

However:

- The trust planned and provided services in a way that met the needs of local people.
- There had been significant improvements in referral to treatment times since our last inspection, with consistently good overall compliance of over 95%.
- The service took account of the individual needs of children and young people including those with learning disabilities. The unit had a learning disability champion and encouraged the use of learning disability passports to help inform decision making.
- The community children's nursing team and continuing care team supported transitional care needs and children with long term conditions. The team promoted bringing care closer to home and worked with children and young people to prevent and reduce hospital admissions.
- Staff were passionate about their work toward children and their families and focused on delivering patient centred care.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- Mandatory training rates for medical staff were low including for safeguarding level 3 training.
- Staffing remained a challenge for the service. There were significant vacancies in the community children's nursing team however the trust was advertising to the vacant posts at the time of our inspection.
- It was difficult to provide the levels of staffing required with the staffing establishment on the children's outpatients and day care unit.
- There was no protocol or standard operating procedure for staff to follow if a child or young person became unwell on the outpatients and day care unit.
- The named nurse for safeguarding children and young people covered three hospital sites however we were not assured that this was sufficient cover for all three hospital sites.
- The service still did not have a flagging system to identify young people aged 16 – 18 who had been admitted to adult wards.

Services for children and young people

- Staff we spoke with felt learning was not shared effectively however the trust told us there were cross site governance meetings where staff could attend where learning was shared.

However:

- COSHH assessments were now all fully completed and up to date.
- All nursing staff were trained in Paediatric Immediate Life Support.
- The service now had comprehensive cleaning schedules with compliance audits.
- Rooms which stored chemicals now had a keypad lock.
- The safeguarding children and young people policy was now in date.

Is the service effective?

Requires improvement 

Our rating of effective went down. We rated it as requires improvement because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. However, a number of trust clinical guidelines and policies had not been reviewed in line with trust timescales.
- Staff on the children's outpatients and day care unit did not receive clinical or safeguarding supervision.
- Nursing staff had not received training in the recognition and management of children with sepsis.
- Children's weights were not always recorded on prescription charts.
- Similarly to the last inspection, the service continued to perform worse than the England average for the National Paediatric Diabetes audit.
- There was no longer a play specialist team at the hospital. A play specialist was being recruited but the post was to be shared with the other hospital site.
- The unit assessed patients' pain using a standardised tool which was child friendly however there was no tool available to help assess the level of pain for patients with communication difficulties.
- Children's services at Ealing Hospital was not a seven day service and ran from 8:30am to 5:30pm Monday to Friday.
- Health promotion information on the children's outpatients and day care unit for patients and their families was limited.

However:

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Consent was sought and clearly recorded in the patients' notes.
- There was evidence of effective multidisciplinary partnership working with external agencies and professionals.

Is the service caring?

Good 

Services for children and young people

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

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff were passionate about their work toward children and their families and focused on delivering patient centred care.
- There was a high level of emotional support provided by staff in the children's outpatients unit and day care unit to help minimise distress.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Friends and Family test results were consistently very good for the children's outpatients unit, day care unit and community services at Ealing Hospital.

Is the service responsive?

Good  

Our rating of responsive improved. We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people. There had been significant improvement in referral to treatment times since our last inspection with consistently good overall compliance of over 95%.
- The service provided a one-stop allergy clinic where children received a range of allergy tests where appropriate all on one day to avoid the need for another appointment.
- The service took account of the individual needs of children and young people including those with learning disabilities. The unit had a learning disability champion and encouraged the use of learning disability passports to help inform decision making.
- The children's outpatients and day care unit was very flexible with appointment times to suit the needs of children and their families.
- The community children's nursing team and continuing care team supported transitional care needs and children with long term conditions. The team had strong links with the community including schools and school nurses and promoted bringing care closer to home.
- The service had specialist nurses in specialities such as diabetes, asthma, sickle cell and thalassemia who worked with children and young people in the community to prevent and reduce hospital admissions.
- The hospital provided hot food and snacks for children and young people on the day care unit. The menus included options for specific cultures and needs.

However*:*

- The new centralised appointment booking system did not always send patients cancellation letters and staff at Ealing Hospital were unable to access the system.
- Adult outpatient areas where children were seen were not child friendly.
- There was no longer an area for adolescents on the unit. Young people had access to Wi-Fi however other facilities for young people were limited.

Services for children and young people

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- The amount of time managers dedicated to the children's services at Ealing Hospital remained very limited.
- The Women and Children's division did not have oversight of young people admitted to adult wards at Ealing Hospital.
- We were not assured that there was sufficient oversight of the children's services at Ealing Hospital. The risk register did not reflect concerns around monitoring of young people admitted to adult wards, the lack of clinical supervision for nursing staff and staffing levels on the outpatients and day care unit.
- Staff still felt unsettled and uncertain about the future provision of children's services at the hospital and felt communication from the trust lacked clarity.
- Consultant paediatricians felt the flow of information from the paediatric senior management team to the consultant body was not effective.
- The closure of the Rapid Access Clinic service had not been made clear on the trust's website.
- While staff felt comfortable escalating issues to management, it often took a long time to resolve because approval had to come from Northwick Park Hospital.

However:

- There was a positive local culture on the children's outpatients and day care unit which valued staff and was based on shared values. Staff described a supportive local team and a child-focused environment.
- Staff were passionate about their work on the unit and there was an open and honest culture within the local team at Ealing Hospital.
- Staff awareness of the trust values had improved.

Areas for improvement

The trust MUST:

- Improve compliance with mandatory training especially for medical staff.
- Provide nursing staff with training in the recognition and management of children with sepsis.
- Provide nursing staff with clinical and safeguarding supervision.
- Ensure a protocol is easily accessible and available for staff to follow if a child or young person became unwell on the unit.
- Have clear oversight of young people admitted to adult wards.
- Improve staffing levels including staffing establishment on the children's outpatients and day care unit.

The trust SHOULD:

- Ensure all clinical guidelines and policies for children's services have been reviewed in line with trust timescales.

Services for children and young people

- Ensure that adult outpatient areas where children were seen are child friendly.
- Improve facilities for adolescents on the children's outpatients and day care unit.
- Provide information leaflets in languages other than English.
- Increase health promotion information available on the children's outpatients and day care unit for was limited.
- Increase engagement with the public in improvement and design of the service.
- Ensure management dedicate adequate time to the Ealing Hospital site.

Community dental services

Good ↑

Key facts and figures

Trust provides dentistry services from three health centres. The service provides specialist services in periodontology, endodontics and prosthodontics for all age groups who require a specialised approach to their dental care and are unable to receive this in a General Dental Practice. As of April 2017 the service ceased providing special care dental services. These services were provided by another trust who share facilities with the community dental services.

Community dental services are provided at the following locations:

- Acton Health Centre on Monday, Wednesday and Thursday. The services provided are periodontics, prosthodontics and dental hygiene.
- Heart of Hounslow Centre for Health on Monday, Wednesday, Thursday and Friday. The service provided is endodontics.
- Wembley Centre for Health on Monday, Wednesday, Thursday and Friday. The services provided are periodontics, endodontics and dental hygiene.

Data provided by the trust showed that between April 2017 and June 2018 there was a total of 715 first appointment visits. This consisted of 446 first appointments for endodontics, 250 for periodontics and 19 for prosthodontics.

We spoke with three patients and eight members of staff during our visit. We observed care and treatment and looked at a small sample of dental care records. We also interviewed key members of the management team.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Staff reported incidents appropriately and they were investigated.
- Staff understood their safeguarding responsibilities and were aware of the safeguarding policies and procedures. Staff had up to date safeguarding training at the appropriate level.
- Medicines were stored, handled and administered safely.
- Risk assessments such as Legionella and fire safety had been completed and there were action plans in place.
- Appropriate systems were in place to respond to medical emergencies.
- Equipment was well maintained and fit for purpose.
- Staffing levels were appropriate and met patients' needs at the time of inspection.
- Patients' individual care records were comprehensively written in a way that kept people safe. Relevant information was recorded appropriately and staff had access to relevant details before providing care.
- Standards of cleanliness and hygiene were generally well maintained. Systems were in place to prevent and protect people from a healthcare associated infection.
- Staff had the necessary qualifications and skills they needed to carry out their roles effectively. Further training and development opportunities were available for staff.

Community dental services

- Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice.
- The service followed effective evidence based care and treatment policies which were based on national guidance.
- There was evidence of good multidisciplinary working with staff. Teams and services worked together to deliver effective care and treatment.
- During the inspection, we saw and were told by patients, that all staff working in the service were kind, caring and compassionate at every stage of their treatment.
- People were treated respectfully and their privacy was maintained in person and through the actions of staff to maintain confidentiality and dignity.
- Staff involved patients in aspects of their care and treatment. Information about treatment plans was provided to meet the needs of patients.
- There was an effective system to record concerns and complaints about the service.
- Staff told us that they felt supported by their immediate line managers and that the senior management team were visible within the department.
- There was a very positive and forward looking attitude and culture apparent among the staff we spoke with.

However, we found that:

- Mandatory training was provided for staff. The service did not meet the trust's target of 85% completion for mandatory training in manual handling - level 2 (face to face), information governance and Resuscitation (basic life support).
- The service had not completed X-ray audits in the last 12 months.
- The service did not have a comprehensive risk register. The risk register did not include the need to update the information technology including the software for the electronic dental care records. The service had not considered the risk of the clinical director managing the service on one day per week employment. The waiting list for endodontic treatment was 14 months at the Heart of Hounslow Centre for Health and there were 360 patients on the waiting list.

Is the service safe?

Good  

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

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. The dental service used the trust's electronic incident reporting system to identify and investigate safety incidents.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. The clinical environment was clean, clutter free and bright. Standards of cleanliness and hygiene were generally well maintained.
- Generally the service had suitable premises and equipment and looked after them well. Equipment was well maintained and fit for purpose.
- Radiography equipment was maintained by specialised technicians to ensure it was safe to use and X-ray equipment was maintained according to recognised safety guidelines.

Community dental services

- The service stored medicines well. Equipment and medicines required for medical emergencies were maintained in accordance with Resuscitation Council and British National Formulary guidelines.
- The service planned for emergencies and staff understood their roles if one should happen. Appropriate equipment and processes were available to respond to medical emergencies.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- Patients' individual care records were written in a way that kept people safe. Staff had access to patient information prior to providing patient care.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Dental service staff received adult safeguarding and children protection training and were confident in their knowledge of how to escalate concerns.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- Staffing levels were adequate to meet patient need at the time of our inspection. There was a good staff skill mix across the service.

However, we found that:

- We found the learning from incidents was not always shared with the wider team.
- Risk assessments such as Legionella and fire safety had been completed and there were action plans in place. The service did not have oversight of these action plans to ensure all outstanding actions were completed.
- Mandatory training was provided for staff. The service did not meet the trust's target of 85% completion for mandatory training in manual handling - level 2 (face to face), information governance and Resuscitation (basic life support).

Is the service effective?

Good ↑

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

- The service had completed an audit which compared the results of the basic periodontal examination of the referring general dental practitioner with those of the specialist at the first appointment visit. The service also audited the number of patients seen for the first appointment visit and those who completed the course of treatment.
- The specialist had participated peer reviews. The most recent peer review was discussing endodontic treatment cases and reviewing the draft specification for procurement of the services.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers had systems in place to make sure staff followed guidance.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff worked together as a team to benefit patients.

Community dental services

- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to paper based records system that they could all update.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However, we found that:

- The service had not participated in national audits to improve patient outcomes.

Is the service caring?

Good 

Our rating of caring improved. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress.
- Staff recognised the different requirements of each patient and treated them as individuals.
- During the inspection, we saw that all staff working in the service were kind, gentle and caring to patients throughout their treatment.
- People were treated respectfully and had their privacy and dignity maintained at all times.
- Patients we spoke with during our inspection were very positive about the way they were treated. The Friends and Family Test results showed a very high level of satisfaction with the service.
- Staff we spoke with were very dedicated to providing the best possible care for all of their patients.

Is the service responsive?

Good 

Our rating of responsive improved. We rated it as good because:

- During our last inspection we were concerned patients did not always have access to care and treatment needed in a timely manner due to waiting times for specialist services (endodontics and periodontics). We found the waiting list had improved at Wembley Centre for Health and Acton Health Centre.
- The service implemented a new triage procedure where the dentists would review the patient referral to determine whether the patient met the referral criteria. The waiting list had also been revalidated.
- The waiting list had been reduced at Wembley Centre for Health. In April 2017 the waiting list for periodontics was six months, with 50 patients on the waiting list, and endodontics 20 months, with 160 patients on the waiting list. In June 2018 the waiting list was reduced to four months for periodontics, with 25 patients on the waiting list, and five months for endodontics with 55 patients on the waiting list.

Community dental services

- The waiting list had been reduced at Acton Health Centre. In April 2017 the waiting list for periodontics was five months, with 56 patients waiting for treatment, and prosthodontics eight months with 20 patients on the waiting list. In June 2018 the waiting list was reduced to four months for periodontics, with 30 patients on the waiting list, and prosthodontics six months with 16 pattients on the waiting list
- The trust planned and provided services in a way that met the needs of local people.
- General dental practitioners referred patients to the service for short-term specialised treatment. The service developed a set of acceptance and discharge criteria so that only the most appropriate patients were seen by the service.
- There were systems to ensure that services were able to meet the individual needs, for example, for nervous patients.
- Generally, the service planned to take account of the needs of different people reflecting the diversity of the local community. Patients from all communities could access treatment in the service if they met the service's criteria.
- There were systems and processes in place to identify and plan for patient safety issues. This included potential staffing and clinic capacity issues.
- There was easy access for patients with physical disabilities and wheel chairs could be accommodated.

However, we found that:

- The waiting list at Heart of Hounslow Centre for Health had not been significantly reduced. In April 2017 the waiting list for endodontics was 15 months with 340 patients on the waiting list. In June 2018 the waiting list had reduced to 14 months. However, the number of patients on the waiting list increased to 360.

Is the service well-led?

Good ↑

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

- During the last inspection we found staff did not know the trust's vision and strategy and it was not visible at the local level. Staff felt the service was stand alone and there was little involvement with the trust. Trust-level management was not visible. Managers within the service were based at a location separate to where the services were located. Their time was split between there and the service locations. Some staff felt that the absence of managers was an issue at some locations.
- Upon reinspection we found this had improved by the service employing a nurse matron and lead dental nurse who were responsible for the day to day running of the service. Staff knew the trust's vision and strategy and attended clinical governance meetings. There was a higher level of engagement and communication from the trust through a newsletter and regular emails. The chief executive of the trust visited the service to speak with staff. The clinical director, nurse matron and lead dental nurse visited each location frequently and staff told us these visits were beneficial
- The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- The service had effective assurance systems and performance measures to monitor its quality.

Community dental services

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The clinical director maintained overall responsibility and accountability for the running of the service.
- A nurse matron and lead dental nurse were responsible for the day to day running of the service and provided support to the clinical director.
- The local management team was visible and accessible to staff and the culture was open and transparent.
- Staff members we spoke with told us the service was a good place to work and that they would recommend it to family members or friends.
- The staff we spoke with said they felt well supported by the management team. Staff told us they could raise any concerns and they were confident these would be addressed and dealt with in a timely manner.
- The culture of the service was one of continuous learning and there was a drive to improve services.

However, we found that:

- The service had not completed X-ray audits in the last 12 months.
- The service did not have a comprehensive risk register. The risk register did not include the need to update the information technology including the software for the electronic dental care records. The service had not considered the risk of the clinical director managing the service on one day per week employment. The waiting list for endodontic treatment was 14 months at the Heart of Hounslow Centre for Health and there were 360 patients on the waiting list.

Areas for improvement

Action the service SHOULD take to improve

- The provider should ensure there is oversight of risk assessment action plans and all outstanding actions are completed.
- The provider should ensure mandatory training is completed in line with the trust mandatory requirements.
- The provider should ensure radiography audits are completed annually to improve the quality of the service.

Community health inpatient services

Good ↑

Key facts and figures

Community inpatient services were provided from two community hospitals. Clayponds Hospital is a community hospital for rehabilitation based in south Ealing. It has two wards: Jasmine ward, for general rehabilitation, and Rosemary ward for general and neurological rehabilitation. Both have 25 beds. The Willesden Community Rehabilitation Hospital is based within the Willesden Centre for Health and Care, which also hosts a number of other services such as GP services and outpatient clinics. It provides general and specialist neurological rehabilitation. The hospital consists of three twenty bed wards; Fifoot, Robertson and Furness.

Each ward has single sex bays and some single side rooms used according to clinical need. Admissions mainly come from the acute hospitals of London North West Healthcare NHS Trust but also from neighbouring trusts where patients are registered with a GP in Ealing, Brent or Harrow. People are cared for by multidisciplinary teams that include nurses, therapies staff and medical staff. Length of stay is for four to six weeks with many admissions being less.

This inspection was announced. We spoke with 15 patients and five relatives. We spoke with 30 members of staff that included nurses, healthcare assistants, therapies staff and medical staff. We spoke with senior nurses and all three directorate leads.

We visited all areas of both of the community hospitals. We reviewed 15 patient records and checked equipment in all areas we visited.

Summary of this service

Our rating of this service improved. We rated it as good because:

- Patient risk was effectively monitored through a multidisciplinary team approach. There was a clear process for identifying and responding to deteriorating patients, who were transferred to the acute hospital if necessary. Incidents were consistently and properly investigated and the outcomes fed back to staff.
- The community hospitals were clean. Cleaning schedules were followed and staff observed infection prevention protocols.
- Clinical staff were following NICE and other clinical guidance. Therapy teams effectively monitored patient outcomes.
- There was good and effective multidisciplinary team working, who provided one joined up service and provided patients with good outcomes.
- Health promotion was seen as an important part of preparing people to go home and to meeting patient need.
- Relatives and patients all told us that staff were compassionate. We were given clear examples of this, which included for patients who were more vulnerable or who had extra need.
- Senior staff told us of the professional expectation they had of staff and we witnessed staff working compassionately against the backdrop of staffing pressures.
- Community hospitals were aware of their integral role in trust pathways and worked well with both acute and community teams. Multidisciplinary staffing teams were meeting patient need, many of whom were in vulnerable circumstances.

Community health inpatient services

- There was a service wide admissions criteria and the assessment process was reasonably proficient in identifying inappropriate referrals. The services worked towards discharge from day one.
- There were a low number of formal complaints. The service promoted swift resolution of any issues brought to them by patients and relatives.
- At the last inspection the trust, community leadership team and inpatient hospitals all worked in isolation. At this inspection community hospitals were working as one team, with unified protocols and a shared culture.
- At the last inspection there was no single clear process of management and clinical governance across the community hospitals. At this inspection there was one community hospital leadership group and the meetings structure was a shared one, across community hospital services.
- Meetings were taking place within community inpatient settings to assure themselves of quality monitoring. Audits were routinely occurring within community inpatient services.

However

- We found pockets of large vacancy rates for nurses and a reliance on a low number of bank staff. In some instances, healthcare assistants were being used to fill nurse shifts.
- The use of a safer staffing model for acute settings was being used. It did not adequately measure staffing need in rehabilitation settings and placed further pressure on staff to provide a quality service.
- There was a lack of psychiatry input for neurological patients, which was on the risk register. It meant that assessment of deteriorating mental health conditions, receiving advice on treatment and which medications worked best alongside neurological treatments was lacking.
- There was a lack of on-site security where the Willesden Community Rehabilitation Hospital was located. This raised a number of potential risks and was on the trust risk register. There were measures in place to keep wards secure. However, incidents that involved neurological patients becoming agitated or self harming had to be supported by ward staff only and remained a risk.
- There was a lack of supervision for lower grade doctors and out of hours medical support to the wards.
- The average length of stay on Robertson ward was stated as six to eight weeks, but many were going beyond this due to unmet social needs such as appropriate housing options.
- Community hospital staff experienced poor, time consuming access to essential online information systems.
- The divisional performance reports did not provide a complete picture of how community hospitals were performing. It was therefore not clear how the board were assured on how community hospitals were performing.
- A new trust medical director had reviewed medical cover and agreed that the current level of input would remain and the duty of care remained consultant led. However, there were gaps in supervision of junior grade doctors and out of hours support to the wards.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

Community health inpatient services

- At the last inspection we found high vacancy rates for nurses at all of the community hospitals and that too many agency nurses with less knowledge of the patients and the unit were being used. This was not the case at this inspection. However, we found pockets of large vacancy rates for nurses and a reliance on a low number of bank staff. In some instances, healthcare assistants were being used to fill nurse shifts.
- The use of a safer staffing model for acute settings was being used. It did not adequately measure staffing need in the community hospitals, which were rehabilitation settings, and placed further pressure on staff to provide a quality service.
- Information contained in divisional performance reports that related to community hospitals was limited. However, executive summaries contained information about two issues requiring improvement that were affecting performance. Junior medical cover was one and the vacant clinical neurological psychology post for Robertson and Rosemary wards was the other.
- Psychiatry input on Robertson ward at the Willesden Community Rehabilitation Hospital had been withdrawn in December 2017. Psychologist support helped with supporting mental health needs and multidisciplinary team work monitored risk through ongoing assessment of patient need. However, lack of psychiatric input meant that assessment of deteriorating mental health conditions, advising on treatment and which medications worked best alongside neurological treatments were still lacking.
- A ligature risk was identified in patient bedrooms on Robertson ward. Immediate action was being taken to minimise this risk.
- There was a lack of on-site security at the centre, where the Willesden Community Rehabilitation Hospital was located. This raised a number of potential risks and was on the trust risk register. The ward doors of the community hospital wards remained locked. Any incidents that involved neurological patients becoming agitated or self harming would have to be supported by ward staff only and was a risk.
- At the Willesden Community Rehabilitation Hospital, we found out of date equipment on the resuscitation trolleys, despite staff signing to state that they had been regularly checked. This was rectified while we were on site.
- There was a lack of supervision for lower grade doctors and out of hours medical support to the wards.

However:

- At the last inspection we found that incidents were consistently and properly investigated and the outcomes fed back to staff. On this inspection we found this was also the case.
- At the last inspection we found that the community hospitals were effective at making sure only suitable low risk patients were admitted. At this inspection we found a similar picture supported by one admissions criteria for community hospitals.
- The hospitals had a clear process for identifying and responding to deteriorating patients, who were transferred to the acute hospital if necessary. Patient risk was being effectively monitored through a nursing and multidisciplinary team approach.
- Appropriate equipment was available and had been suitably maintained.
- Staff had been trained in safeguarding to appropriate levels and were aware of referral and escalation protocols.
- The community hospitals were clean. Cleaning schedules were followed and staff observed infection prevention protocols.
- The completion of patient records supported the positive team approach to care.

Community health inpatient services

Is the service effective?

Good ➔➔

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

- At the last inspection we found that clinical staff were following NICE and other clinical guidance. At this inspection we found this was still the case. Therapy teams effectively monitored patient outcomes.
- Patient outcomes were being appropriately measured within community inpatient services and compared favourably with national averages.
- At the last inspection we found multidisciplinary teams worked well together to provide patients with good outcomes. At this inspection we found this was still the case. Throughout our visit we encountered good and effective multidisciplinary team working between the nursing team, medical team and therapies team, who provided one joined up service.
- There was good communication between the two community hospitals, with the therapies team led by the same team leader and the nursing team meeting up at regular intervals to discuss service issues.
- At the last inspection we found staff understood their responsibilities regarding consent for patients who may lack mental capacity. At this inspection we found this was still the case.
- Patient nutrition, hydration and pain were being effectively managed.
- Health promotion was seen as an important part of preparing people to go home and to meeting patient need.

However:

- Staff were trained to identify deteriorating patients. At Clayponds Community Hospital, there were two nurses trained as advanced nurse practitioners (ANPs) and two nurses trained to carry out physical assessments with another in training. This supported patients when there was no medical cover on the wards including out of hours. However, at the Willesden Community Rehabilitation Hospital there were no ANPs and no nurses who were trained to carry out physical assessment.

Is the service caring?

Good ➔➔

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

- At the last inspection we found that all the patients and families we spoke with were very positive about the care they had received in the community hospitals. At this inspection relatives and patients all told us that staff were caring and compassionate. They gave us clear examples of how staff had made patient admissions a good experience because of caring staff, which included for those who were more vulnerable or who had extra need.
- All of the staff we observed and spoke with were aware of the need to be caring and compassionate in their work.
- Senior staff told us of the professional expectation they had of staff and we witnessed staff working compassionately against the backdrop of staffing pressures.
- We observed patient privacy and dignity being protected in interaction with staff and while receiving care.

- Patient choice was respected.
- Patients were involved in the care and treatment they received and relatives felt involved in the care too.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- Community inpatient services were aware of their integral role in trust pathways and worked well with both acute and community teams.
- The service was aware of its changing demographic and the changing patient need.
- Changes had been made to wards to make them more dementia friendly.
- Therapies staff led groups on a variety of activities and worked with patients individually, which was tailored around need.
- Multidisciplinary staffing teams at both community hospitals were meeting patient need, many of whom were in vulnerable circumstances.
- There was a service wide admissions criteria and the assessment process was reasonably proficient in identifying inappropriate referrals. The services worked towards discharge from day one.
- There were a low number of formal complaints. The service promoted swift resolution of any issues brought to them by patients and relatives.

However:

- Psychology support was limited. However, a business case had been approved for two full time clinical psychology posts to cover both community hospital sites.
- The average length of stay on Robertson ward was stated as six to eight weeks, but many were going beyond this due to unmet social needs such as appropriate housing options.

Is the service well-led?

Good ➔

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

- At the last inspection the trust, community leadership team and inpatient hospitals all worked in isolation. At this inspection community hospitals were working as one team, with unified protocols and a shared culture.
- At the last inspection there was no single clear process of management and clinical governance across the community hospitals. At this inspection there was one community hospital leadership group and the meetings structure was a shared one, across community hospital services.
- The leadership team had taken positive steps to ensure that staff felt included in the bigger trust picture and did not feel cut off, especially post trust merger.
- The service had wide ranging activity that covered the management of risk, issues and performance.

- The local risk register for Willesden and Clayponds demonstrated that risks were being identified and acted on.
- Meetings were taking place within community inpatient settings to assure themselves of risk and quality monitoring.
- Audits were routinely occurring within community inpatient services.

However:

- A new trust medical director had reviewed medical cover and agreed that the current level of input would remain and the duty of care remained consultant led. However, there were gaps in supervision of junior grade doctors and out of hours support to the wards.
- Community hospital staff experienced poor, time consuming access to essential online information systems.
- The divisional performance reports did not provide a complete picture of how community hospitals were performing. It was therefore not clear how the board were assured on how community hospitals were performing.
- We identified a risk to individual patients posed by the physical environment, namely ligature points in patient bedrooms, which had not been identified by the service through their own risk processes.

Outstanding practice

- Relatives and patients all told us that staff were caring and compassionate. They gave us clear examples of how staff had made patient admissions a good experience which included for those who were more vulnerable or who had extra need. All of the staff we observed and spoke with were aware of the need to be caring and compassionate in their work and we witnessed staff working compassionately against the backdrop of staffing pressures.

Areas for improvement

We found areas for improvement in this service.

Action the trust MUST take to improve

Lack of psychiatric input on Robertson ward meant that assessment of deteriorating mental health conditions, advising on treatment and which medications worked best alongside neurological treatments were unmet patient need. The lack of security presence on the premises meant that the ward had been vulnerable when supporting agitated patients. Ward staff did what they were able to minimise risks, but without psychiatric input or security presence, they remained vulnerable to future incidents. The trust must ensure that mental health needs of its patients are met.

Action the trust SHOULD take to improve

The trust should review how it measures nursing staffing need so that it adequately reflects the needs of a rehabilitation service.

The trust should review its practice of reliance on a small number of bank staff and ensure that where healthcare assistants are filling nursing shifts, that this is properly risk assessed.

The trust should reviewed medical cover to account for gaps in supervision of junior grade doctors and out of hours support to the community hospitals.

The trust should adequately ensure that risks posed by lack of security presence at Willesden are minimised/ lack of security presence at Willesden is resolved to keep patients safe.

The trust should ensure the supervision for lower grade doctors.

Community health inpatient services

The trust should consider increasing the skill mix of nurses at the Willesden Community Rehabilitation Hospital in order to support patients when there was no medical cover on the wards, where there were no nurses trained as advanced nurse practitioners or trained to carry out physical assessments.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Maternity and midwifery services	Section 29A HSCA Warning notice: quality of health care

Regulated activity	Regulation
Treatment of disease, disorder or injury	Section 29A HSCA Warning notice: quality of health care

Regulated activity	Regulation
Treatment of disease, disorder or injury	Section 29A HSCA Warning notice: quality of health care

Regulated activity	Regulation
Treatment of disease, disorder or injury	Section 29A HSCA Warning notice: quality of health care

Regulated activity	Regulation
Treatment of disease, disorder or injury	Section 31 HSCA Urgent procedure for suspension, variation etc.

Our inspection team

Monisha Parmar CQC inspector led, organised and managed both inspections at the trust.

Nicola Wise, Head of North London Hospital Inspections led the well-led inspection.

Robert Throw CQC inspection manager was the lead inspection manager for the trust and conducted the well-led review.

An executive reviewer, David Rogers, supported our well-led inspection. Specialist advisers and experts also supported this inspection.

The core service inspection team included two CQC inspection managers, the CQC relationship owner of the trust, inspectors, specialist advisers, and experts by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.