The Hillingdon Hospital

Evidence appendix

Venue: The Hillingdon Hospital

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Uxbridge,
Middlesex,
UB8 3NN

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Date of publication: 24 July 2018

This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

The Hillingdon Hospitals NHS Foundation Trust provides services from both Hillingdon Hospital and Mount Vernon Hospital. The Trust has a turnover of around £222 million and employ over 3,300 staff. They deliver healthcare to the residents of the London Borough of Hillingdon, and increasingly to those living in the surrounding areas of Ealing, Harrow, Buckinghamshire and Hertfordshire, giving them a total catchment population of over 350,000 people.

Hillingdon Hospital is an acute and specialist services provider in North West London, close to Heathrow Airport for which we are the nearest hospital for those receiving emergency treatment. Providing the majority of services from the Trust, Hillingdon Hospital is the only acute hospital in Hillingdon with a busy Accident and Emergency, inpatients, day surgery, and outpatient clinics. The Trust also provides some services at Mount Vernon Hospital, in co-operation with the East & North Hertfordshire NHS Trust.

The trust has 509 beds including:
- 295 medical care beds;
- 95 surgery beds;
- 60 maternity beds;
- 25 paediatric beds;
- 20 neonate beds;
- 10 gynaecology beds;
- and 9 ITU beds
Is this organisation well-led?

Leadership
The trust board had the appropriate range of skills, knowledge and experience to perform its role. The board was comprised of a non-executive Chair, six non-executive directors and six executive directors (one non-voting) including the chief executive. All the executive directors were substantive. The Chair joined the trust in 2014 and the Chief Executive was appointed in 2011. The rest of the executive directors were appointed between 2007 and 2018. The non-executive directors were appointed between 2014 and 2017.

The trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience. The board comprised of individuals with senior level experience in both the public and private sectors, across a range of disciplines including clinical and patient care, health service leadership, commercial development, business transformation, change management and human resources.

We were unable to directly identify from trust documentation, a trust-named lead for child and adolescent mental health, learning disability and autism. We identified the lead for children generally as the Director of Nursing and there was an adult safeguarding nurse lead identified on the trust website with the implication but not direct identification that the role also extended to children without mentioning children’s mental health. We looked at the business plan for the women and children’s division as well as the overall trust strategy. Although the latter referred to services for child mental health as part of the local health economy’s Sustainability and Transformation Plan (STP) there was high level reference only. It was recognised that CAMHS provision was stretched but there were close relationships with NHSE who ran the CAMHS service and the local mental health trust. The trust participated in the Child Health Outcome Review Programme: Chronic neuro-disability and Young People’s mental health.

The trust board and senior leadership team displayed integrity on an ongoing basis. An example of this was the board’s decision that it could not agree or accept the cap on expenditure (control total) offered by the NHS for 2017, despite the fact that this would have given access to national sustainability and transformation funding and other financial benefits. This decision was based on the board’s belief that it could not honestly operate within that control total.

Fit and Proper Person checks were in place, although there were some gaps in documentation. The trust uses an outsourced agency to obtain its DBS checks. There was evidence of some oversight by the trust; however we were not fully assured of consistency. For example, some files had interview notes while others did not, and we found a misfiled letter in one file. We found that an insolvency check/qualifications check had been printed out for 2017/18 and an internal audit had taken place in February 2018 just prior to our core service inspection. However there was a gap for 2016 and the annual declaration of Fit and Proper Persons had not happened every year. We did not see evidence from board papers that an annual assurance had been placed in front of the board director for FPPR. We saw that some had checks had been carried out after appointment. There did not appear to be a clear delineation of responsibility between HR for the process and the board via the board secretary for assurance.
When senior leadership vacancies arose the recruitment team reviewed capacity and capability needs. When two non-executive director vacancies recently arose, a skills gap analysis was undertaken and an agency was appointed to source the skills required. We were told that since the recruitment the capacity of the board was enhanced.

The trust reviewed leadership capacity and capability on an ongoing basis. The Chair confirmed that he was continually reviewing the capacity and individual capabilities of the senior leadership team.

The trust leadership team had a comprehensive knowledge of current priorities and challenges. Key risks were identified and included failure to achieve the 95% A&E target; failure to remain within hospital acquired infection thresholds; lack of interventional radiology on call; lack of a commissioned service to deliver high dependency care for children; lack of financial capacity to improve the trust’s estate; lack of staffing to ensure delivery of high quality care; failure to meet standards set by the regulators; failure to achieve its financial plan, and failure to modernise and reconfigure its estate.

The trust report and accounts stated that there were regular visits to clinical departments by the chief executive and other board members giving them the opportunity to talk to staff and patients about their experience. We were told by the chief operating officer that board executives and non-executive directors undertook ward rounds and reported themes coming out of those visits such as lack of resources. They completed summary report every 2-3 months. This statement on visibility did not always appear to be borne out or wholly recognised by trust staff in all departments. During our core service inspection, while the chief executive and director of nursing were recognised as visiting on general medical wards and staff on the children’s wards stated that executive team members sometimes visited, staff in critical care stated that the executive team were not visible and staff in outpatients stated that visits from the executive team were rare and that apart from the chief executive, other members of the executive team were not recognisable.

Leadership development opportunities were available, including opportunities for staff below team manager level and this was beginning to be further developed. We spoke to several members of staff who had taken part in the trust’s Leadership in Action development programme. The trust recognised that it was at significant risk due to inability to attract, recruit and retain sufficient staff. It stated that a range of initiatives had begun to support the development of existing staff alongside recruitment of new staff. This was in partnership with external partners and centred on a new academic centre for health sciences. The 2016/17 trust annual report and accounts stated that this would support the development of knowledge, skills and research. This was launched in November 2017.

Succession planning was in place in the trust though this was not embedded at all levels. According to the board meeting minutes of January 2017 an extreme risk was identified due to the lack of sufficient talent management and succession planning to ensure robust leadership particularly across clinical leadership roles at divisional level. To mitigate this it was planned to run quarterly developmental reviews to improve the quality of personal development reviews (PDRs) to promote experiential learning and drive talent management and succession planning.

This issue was revisited in the April 2017 board meeting when the risk was highlighted again and the Board Strategic Plan for 2017-21 stated the aim to “manage our talent and develop our brand so that we attract, grow and retain the brightest and best and ensure leadership into the future” including supporting consultant talent management and succession planning at all levels.
The lack of talent management and succession planning was again raised as a risk at the July 2017 meeting. In the September 2017 meeting, in response to the annual NHS Staff survey 2016, the board was told that, as part of succession planning, the trust was designing development centres for staff to better manage talent and develop future leaders. In the board meeting of January 2018 the board declared itself assured in the Board Assurance Framework in relation to the succession planning risk. In the March 2018, the board secretary identified board succession planning as an area of good practice in the board’s self-assessment.

According to the trust’s People Strategy published in 2017 and covering five years to 2021 this development was in its early stages. The establishment of targeted talent management and succession planning was identified as a year one to two target from 2017. An in-house management development programme including clinically led talent management and succession planning embedded across the trust was identified as a year three to four milestone.

We noted from the core service inspection held between 6-8 March 2018 that four core services had managed to improve their rating from requires improvement to good while three remained with no improvement and two had gone down in ratings to inadequate. This improvement was due to leadership at divisional and local level.

Of the executive board members at the trust, 28.5% were British Minority Ethnic (BME) and 14.3% were female. Of the non-executive board members 12.5% were BME and 50% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>28.5</td>
<td>14.3</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>12.5</td>
<td>50.0</td>
</tr>
<tr>
<td>All board members</td>
<td>20.0</td>
<td>33.3</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

**Vision and strategy**

The trust had a clear vision and set of values with quality and sustainability as the top priorities. The trust vision and strategy took account of the health economy of North West London and the need to change the method of delivering care by 2021, providing more acute care away from the trust’s hospitals. It encompassed joining with the adjacent university to bring together education, research and health provision. It also took account of Shaping a Healthier Future and the local Sustainability Transformation Plan (STP). The preferred estates option included the building and provision of a new acute care centre based on the adjacent university site.

There was a strategy for achieving the priorities and developing good quality, sustainable care. We noted that the trust identified the main three enablers of the strategy as being its workforce, its estate and digital development. However, we saw from its risk register and board documentation that the ability to recruit and retain skilled staff remained a major risk alongside a current lack of embedded succession planning. From an estates perspective the strategy for estates was in its very early stages of practical implementation, being dependant on external approval and financial
support to achieve it. We noted little change in relation to the poor estate which had been noted in our previous reports although we noted that the newly appointed director of estates was skilful in maintaining essential services on a day to day basis. We were told verbally that if the plan to develop the acute care centre did not go ahead then attention would be paid to renewing the estate on the current hospital sites, either by obtaining external capital funding or piecemeal within the trust’s own financial resources although the latter two options were not articulated in the trust’s main strategy document.

Local providers and people who use services had been involved in developing the strategy. The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans. The trust had planned services to take into account the needs of the local population. Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services. The Trust established a Lay Strategic Forum made up of patients and carers who use their services providing them with an opportunity to improve the health and wellbeing of the local population, the quality and safety of care and the efficiency and productivity of trust services. Representatives from this group had joined committees and other groups providing a public viewpoint to discussions.

Other engagement was via the local External Services Scrutiny Committee; engagement with local Healthwatch; trust governors; holding regular People in Partnership Forums to listen to the views and opinions of the communities served by the trust; the annual members meeting; engagement with specialist user and support groups, and inviting members of the public and local stakeholders to comment and identify priorities

We found a mixed picture with regard to the staff of the trust identification with trust vision and values. In some areas the trust vision and its underpinning CARES values - of Communication, Attitude, Responsibility, Equity and Safety - were embedded amongst staff in the service. In other areas more emphasis was placed on the vision and values for an individual service which tallied with the overall trust vision and values. Staff in those areas knew and understood the trust vision and values. However in one area, the majority of staff we spoke with were not aware of how their work contributed to the wider vision of the trust. In another area we spoke to staff regarding the trusts vision and they were unable to answer questions on this vision. When we prompted staff in this area on the CARES values staff were able to recall the acronym but not what each letter stood for.

The trust embedded its vision, values and strategy in corporate information received by teams. The trust used its publications of CARES Monthly and its quarterly Pulse Magazine to emphasise key messages and also the conduit of its CARES champions from amongst its staff members.

The leadership team regularly monitored and reviewed progress on delivering the strategy and local plans. The board identified processes to ensure the effectiveness of systems of internal control through the audit and risk committee review of the Board Assurance Framework and corporate risk register; audit and risk committee scrutiny of controls in place and quarterly reporting to the board; board oversight of all significant risks; review of serious incidents and learning at its quality and safety committee and escalation to the board of issues of serious concern; review of progress against CQC fundamental standards; internal audit of effectiveness of systems and internal controls as well as regular board to ward walkabouts plus regular escalation
of issues to the monthly board meeting arising out of these measures. Despite these measures the board appeared to be either unsighted or had not taken action on serious issues we found during our core service inspection which led us to issue the trust with requirement notices relating to breaches of Regulations 12 (Safe care and treatment) and Regulation 17 (Good Governance) of the Health and Social Care Act 2008 specifically in its urgent and emergency care, surgery and outpatients departments.

Culture

The trust workforce compliance report of 2016 identified that BAME staff (Black, Asian, and Minority Ethnic) made up 45% of the trust total workforce of 3962, and that 53% of staff identified as White with 2% non-declaring. This corresponded broadly with the ethnic mix of the local population with a slightly higher representation of white staff when compared with local area figures.

The majority of staff felt they were well-motivated, respected, supported and valued by the trust. Even in those areas where stress levels were higher such as in urgent and emergency care, staff felt proud to work for the trust. On many occasions we heard reference to the “Hillingdon family” and came across instances where staff had left to work elsewhere only to return. The trust was participating in the NHSi National Retention Programme, working on four key areas for improvement including flexible working, staff engagement, promoting respect in the work place and career development.

The trust recognised staff success by staff awards and through feedback. An annual awards ceremony was held where awards were given for compassionate care; outstanding demonstration of CARES values; outstanding demonstration of teamwork; a quality award, and the Chair’s innovation award. In addition there were monthly CARES awards and an award scheme called Pay it Forward. The quarterly Pulse Magazine for patients, carers, staff and public contained articles recognising individual and team contributions and excellence.

However, we became aware that issues relating to the poor estate and the perceived financial limitations on being able to remedy them appeared to have an impact on adherence to quality standards in some areas. This perception was confirmed by at least one senior member of the trust. We found practical examples of this in walking around the Hillingdon hospital site and finding service areas mixed in with areas where patients were moving to their treatment as well as some wards where bed curtains were clearly out of date, and some untidiness in relation to stored equipment.

The trust worked appropriately with trade unions. When we interviewed union and staff side representatives they were positive about relations with the trust senior management. They described them as open and honest and supportive of them as staff representatives. They cited a good recognition agreement with the trust which was encouraging of union membership. Staff representatives said they had a good deal of freedom to act and were consulted on new initiatives and when new agreements needed to be forged. They felt at times that communication could be better and sometimes felt under pressure to accept a less than 30 day consultation period. They commented that the poor estate of the trust was an issue but praised the work to keep the functions of the trust going despite this.
Managers addressed poor staff performance where needed. The director of human resources told us that there were currently ten cases being dealt with under the trust’s capability policy and a greater number of individual sick absence cases. He was not reluctant to take such measures where they were deemed necessary. All were undertaken in consultation with the appropriate staff side representatives.

The trust had appointed a Freedom to Speak Up Guardian and provided them with sufficient resources and support to help staff to raise concerns. The Freedom to Speak up Guardian was appointed in January 2017 and worked 15 hours per week. They described support from different leaders in the trust and a good support from non –executive directors with excellent engagement from front line staff despite some early uncertainty about the role at all levels which quickly dissipated. They had access to an office laptop and discrete files but no other office equipment but did not feel this hampered their role and could have a filing cabinet if they wanted but chose not to. The Freedom to Speak up Guardian had dealt with approximately one hundred claims since appointment of which 43% were about behavioural concerns and bullying; 23% were about patient safety, and 37% contained a mixture including relationship support from management; investigations of staff; staff unsure of polices; working hours queries, and access to training.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. There was a plan in place to appoint Freedom to Speak up champions in every division to support the Guardian; setting up meetings will staff and managers to promote understanding of the role including training. The Guardian felt they had ready access to all managers and senior managers to enable issues to be resolved.

The handling of concerns raised by staff always met with best practice. Staff felt able to raise concerns without fear of retribution. The atmosphere in the trust was described as open and honest, with good working relationships between the senior managers and staff side. There was a sense of a no blame culture where people were free to raise concerns without fear of retribution. There was however a different perception of this between white and BAME staff, the latter citing less opportunity for advancement than their white colleagues and more likely to have been discriminated against. There were no differences between the two groups for staff being bullied by other staff but more white staff reported bullying by patients and carers than their BAME colleagues.

The trust applied Duty of Candour. The trust had integrated Duty of Candour into its incident reporting and being open policies. It stated that processes and systems had been implemented to ensure legal and contractual requirements of Duty of Candour were met. Staff awareness had been raised via training and discussions at divisional meetings. There was a monitoring system managed by governance staff with performance reports to divisional governance boards. Staff told us that they operated within the spirit of Duty of Candour. We looked at complaint letters and found the style of response to be generally good with appropriate levels of response, explanation and apology where things had gone wrong. There were clear indications of named contacts should complainants wish to discuss the response and reference to the health and social care ombudsman should they remain dissatisfied. However when we scrutinised six investigation reports into serious incidents that had occurred between 2016 and 2017, some two to three years after the statutory introduction of Duty of Candour we found some gaps in reference to it. Of the six, one made reference to Duty of Candour having been applied, which would be expected as part of the investigation process, and the remaining five made no reference.
The trust took appropriate learning and action as a result of concerns raised. Most of the ten responses to letters of complaint which we reviewed, contained reference to lessons learnt and most gave an explanation of what had changed as a result of the investigation into the complaint or serious incident. There had been some board discussion questioning the effectiveness of learning from complaints being disseminated. A paper on this was planned for later in the summer of 2018.

All staff had the opportunity to discuss their learning and career development needs at appraisal. 93% of trust staff had received an annual appraisal in the last year which was higher than the national average of 86%. The trust had a culture of regular one to one meetings at all levels. Performance development review meetings allowed staff to be involved in decision making about their work and development. Examples of staff development programmes available included a staff leadership training programme; development programmes for advanced nurse practitioner; skill development for paediatric nurses; junior doctor training; competency frameworks for clinical staff; development programmes to support junior staff to move to higher grade posts and collaboration with a local university aimed at academic and skill staff development.

Staff had access to support for their own physical and emotional health needs through occupational health. The trust has an occupational health department which provides information and support to staff for their health needs as well as when they are sick. In addition the trust has an Employee Assistance Programme which is open to all employees to assist with employee welfare issues.

Sickness and absence figures were not outliers at the trust. The trust’s sickness absence levels from September 2016 to July 2017 were just under one per cent lower than the England average, following a similar pattern over the period.
Staff generally felt equality and diversity were promoted in their day to day work and when looking at opportunities for career progression. There were differences in perception. While 70% of BAME staff believed that the organisation provided equal opportunities for career progression or promotion, this percentage was higher for white staff where 86% held the same belief. Staff networks were in place promoting the diversity of staff. The director of human resources had instigated a BAME staff network but at the time of our inspection there were no other similar official networks for other groups such as LGBT or disabled staff. This was a stated development route for the future.

Teams had positive relationships, worked well together and addressed any conflict appropriately. The trust was in the top 20% of all acute trusts for staff feeling recognised and valued by the organisation and this was reflected in our contact with trust staff at all levels. We did not experience evidence of great conflicts or tensions between different staff or clinical professional groups. Divisions were led by a tripartite senior group representing nurses, doctors and managerial and clerical staff and issues appeared to be resolved amicably.

(Source: **Routine Provider Information Request (RPIR)** – Diversity P6)

**NHS Staff Survey 2017 – results better than average of acute trusts**

The trust had four key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF11. Percentage of staff appraised in last 12 months</td>
<td>93%</td>
<td>86%</td>
</tr>
<tr>
<td>KF4. Staff motivation at work</td>
<td>4.02</td>
<td>3.91</td>
</tr>
</tbody>
</table>

**NHS Staff Survey 2017 – results worse than average of acute trusts**

The trust had four key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF28. Percentage of staff reporting errors, near misses or incidents in last month</td>
<td>87%</td>
<td>90%</td>
</tr>
<tr>
<td>KF23. Percentage of staff experiencing physical violence from staff in last 12 months</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>30%</td>
<td>28%</td>
</tr>
<tr>
<td>KF20. Percentage of staff experiencing discrimination at work in the last 12 months</td>
<td>17%</td>
<td>13%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.
Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

<table>
<thead>
<tr>
<th></th>
<th>Your Trust in 2017</th>
<th>Average (median) for acute trusts</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>White 31% BME 29%</td>
<td>27% 28% 29%</td>
</tr>
<tr>
<td>KF26</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>White 27% BME 27%</td>
<td>25% 27% 24%</td>
</tr>
<tr>
<td>KF21</td>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>White 86% BME 70%</td>
<td>87% 75% 77%</td>
</tr>
<tr>
<td>Q17b</td>
<td>In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?</td>
<td>White 9% BME 17%</td>
<td>7% 15% 12%</td>
</tr>
</tbody>
</table>

Of the four questions above, two questions showed a statistically significant difference in score between White and BME staff:

KF21: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
Q17b: In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?

(Source: NHS Staff Survey 2017)

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

From November 2016 to October 2017, the trust scored better than the England average for eight of the 12 months, recommending the trust as a place to receive care. The remaining four months
scored similar to the England average.

(Source: Friends and Family Test)

**Governance**

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees and team meetings. Leaders regularly reviewed these structures. The board was supported by a number of committees who met regularly to ensure that trust services and systems are performing to expectations. These included: audit and risk committee, remuneration committee, quality and safety committee, finance and transformation committee, nominations committee and charitable funds committee. We saw that there were clear reporting lines to the board from its main sub-committees. Reports were delivered at regular intervals from each committee.

We examined the board papers over the previous twelve months and found that papers for board meetings and other committees were of a reasonable standard and contained generally appropriate information.

The trust provided their board assurance framework 2017/18. The ‘assurance’ column provides a high level assessment to assess overall whether there are sufficient controls, assurance and action plans in place or not, to ensure effective management of risk.

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Risk</th>
<th>Objective</th>
<th>Risk Score</th>
<th>Target</th>
<th>Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery Area 2: Eliminate unwarranted variation and improve LTC management</td>
<td>2.1.2</td>
<td>Progress could be limited unless there is greater involvement from London</td>
<td>12</td>
<td>9</td>
<td>Yes</td>
</tr>
</tbody>
</table>

2.1 Increase number of community based integrated services
| Borough of Hillingdon | 2.4.1 On-going insufficient clinic capacity could hinder improvement in percentage of 2-week referrals | 2.4 Improve diagnosis times IP3 Meet cancer targets | 9 | 6 | No |

**Delivery Area 3: Achieve better outcomes and experiences for older people**

| 3.1.1 Inability to obtain agreement from all partners Revised models of care will be difficult to deliver and require new ways of working – significant resource will be required to delivery this transformation. There is therefore a risk that the operational changes won’t be delivered within the required time scale. | 3.1 Implement ACP and models of care | 12 | 9 | Yes |

**Delivery Area 4: Improve outcomes for children and adults with mental health needs**

| 4.1.1 Inability to discharge Mental Health patients from A&E in a timely manner. | 4.1 Improve the journey for patients requiring mental health support who attend our services | 15 | 8 | No |

**Delivery Area 5: Ensure we have safe, high quality sustainable acute services**

| 5.1.1 Activity exceeds contracted levels negating the impacts gained through the improvement plan, consequently compromising delivery of the FIP | 5.1 Maximise elective flows | 20 | 12 | No |

| 5.2.1 Staff may have insufficient capacity to fully engage with transformation programme. Staff and leadership may not engage with the processes within the patient flow work streams. | 5.2 Implement best practice emergency pathways 5.3 Deliver Health Outreach to community services | 12 | 6 | Yes |

<p>| 5.2.2 Demand management schemes fail to reduce flows into hospital which will overwhelm physical capacity within A&amp;E. | 5.2 Implement best practice emergency pathways IP1 A&amp;E 4-hour standard | 20 | 10 | No |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Action</th>
<th>Current Status</th>
<th>Key</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.2.3</td>
<td>Insufficient capacity in the community to accommodate medical fit patients – this will result in bed blocking.</td>
<td>5.2 Implement best practice emergency pathways IP1 A&amp;E 4-hour standard</td>
<td>20 12 No</td>
<td></td>
</tr>
<tr>
<td>5.4.1</td>
<td>Inability of clinical staff to adapt to change and use the technology (and continue to use paper or phone/fax).</td>
<td>5.4 Deliver Health In-reach providing specialist Advice</td>
<td>12 6 Yes</td>
<td></td>
</tr>
<tr>
<td>5.5.1</td>
<td><em>Inability to implement</em> early consultant review for all admitted patients and ongoing medical reviews thereafter</td>
<td>5.5 Implement the core 7-day service standards</td>
<td>20 15 No</td>
<td></td>
</tr>
<tr>
<td>5.9.1</td>
<td>Failure to implement and sustain delivery of change management as a result of PA consultancy exit</td>
<td>5.9 Deliver in year QIPP programmes</td>
<td>9 6 Yes</td>
<td></td>
</tr>
<tr>
<td>5.9.2</td>
<td>Activity exceeds plan</td>
<td>5.9 Deliver in year QIPP programmes</td>
<td>16 12 Yes</td>
<td></td>
</tr>
<tr>
<td>5.9.3</td>
<td>Robustness of FIP delivery schemes</td>
<td>5.9 Deliver in year QIPP programmes</td>
<td>12 9 Yes</td>
<td></td>
</tr>
<tr>
<td>5.10.1</td>
<td>Financial implications and structural capacity may not be adequate to develop new services</td>
<td>Birthrate plus review and approved phased business case to increase staffing establishment to 1:32. Working as part of the NW London early adopter's project leading on continuity of care and postnatal pathway in line with Better Births.</td>
<td>16 6 Yes</td>
<td></td>
</tr>
</tbody>
</table>

**Enablers - Estates**

<p>| EE1.1 | Full list of assets may not be known; therefore, assets requiring statutory inspection may be missed, and prevent an informed approach to the 5-year plan. | EE1 Ensure safety and regulatory compliance | 12 6 Yes |
| EE1.2 | Financial restraints may restrict investment and reduce rate at which remedial works can be completed. | EE1 Ensure safety and regulatory compliance | 12 12 Yes |
| EE1.3 | Items identified that are | EE1 Ensure safety and regulatory compliance | 12 12 Yes |</p>
<table>
<thead>
<tr>
<th>Enabler</th>
<th>Action Description</th>
<th>Result 1</th>
<th>Result 2</th>
<th>Result 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>not on the Asset Register will require a maintenance and inspection regime which may require additional finance and labour resource.</td>
<td>regulatory compliance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EE2.1</td>
<td>Not knowing the long term strategy may impact in formulating the short to medium strategies.</td>
<td>EE2 Develop short to medium term estate plan</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>EE2.2</td>
<td>Due to the condition of the plant and estate, there is a significant risk of sudden failure that would require reprioritising of the five-year plan to meet business objectives.</td>
<td>EE2 Develop short to medium term estate plan</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>EE3.1</td>
<td>Delay to the production of the Strategic Outline Case for a reconfigured estate will lead to a delay in implementing the Trust masterplan and strategic redevelopment option and therefore a delay in the provision of a suitable for purpose (CQC Regulation 15 premises and equipment) and a financially sustainable estate.</td>
<td>EE3 Develop Strategic options for the redevelopment of both hospital sites</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>EE3.2</td>
<td>Risk that there is no funding strategy identified to implement the chosen strategic redevelopment option.</td>
<td>EE3 Develop Strategic options for the redevelopment of both hospital sites</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>EE3.3</td>
<td>Risk that resource is concentrated on the concept case for the academic health campus resulting in no development of a contingency plan if the academic health campus plans do not materialise.</td>
<td>EE3 Develop Strategic options for the redevelopment of both hospital sites</td>
<td>9</td>
<td>9</td>
</tr>
</tbody>
</table>

**Enabler - Workforce**

<p>| EW1. 1 | Nursing supply - changes to funding for training will | EW1 Improve recruitment | 9       | 6        | Yes       |</p>
<table>
<thead>
<tr>
<th>Enabler</th>
<th>Description</th>
<th>Action Plan</th>
<th>Urgency</th>
<th>Compliance</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>EW1.2</td>
<td>Stringent NMC language requirements impacts on International recruitment</td>
<td>EW1 Improve recruitment</td>
<td>12</td>
<td>6</td>
<td>Yes</td>
</tr>
<tr>
<td>EW4.1</td>
<td>Lack of sufficient talent management and succession planning to ensure robust clinical leadership into the future</td>
<td>EW4 Develop Trust Clinical Leadership</td>
<td>9</td>
<td>4</td>
<td>Yes</td>
</tr>
<tr>
<td>EW5.1</td>
<td>Stakeholder buy-in to new roles across the partnership</td>
<td>EW5.1 Develop Innovation with new roles and ways of working</td>
<td>9</td>
<td>6</td>
<td>No</td>
</tr>
<tr>
<td><strong>Enabler - Digital</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED1.1</td>
<td>Staff fail to engage in moving to digital working (notably for Clinical Handover)</td>
<td>ED1.1 Implement Digital Roadmap ED1.2 Implement ICT Strategy</td>
<td>9</td>
<td>6</td>
<td>No</td>
</tr>
<tr>
<td>ED1.2</td>
<td>Insufficient transformation funds made available by Government for key ICT projects</td>
<td>ED1.1 Implement Digital Roadmap ED1.2 Implement ICT Strategy</td>
<td>12</td>
<td>6</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Improving the present</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IP2.1</td>
<td>Referral activity will continue to exceed available capacity and breach the 18-week standard - Financial position will limit number of WLI’s available to service demand</td>
<td>IP2.1 18-week Referral to Treatment</td>
<td>16</td>
<td>12</td>
<td>Yes</td>
</tr>
<tr>
<td>IP4.4</td>
<td>Competing priorities for quality and safety improvement with limited financial and physical resources e.g. water quality, ventilation, staffing, resource for developing Safety Champions and the QI hub, resources for implementing the new Learning from Deaths Framework for Mortality review.</td>
<td>IP 4 Complete CQC action plan IP5 Implement year 2 of the QSI strategy</td>
<td>16</td>
<td>12</td>
<td>Yes</td>
</tr>
<tr>
<td>IP6.1</td>
<td>Failure to fulfil financial objectives</td>
<td>IP 6 Maintain finance and use of resources score of 3</td>
<td>16</td>
<td>12</td>
<td>Yes</td>
</tr>
</tbody>
</table>
We reviewed the trust’s Board Assurance Framework (BAF), which detailed risks and gaps in the risk controls which could impact upon strategic ambitions. The trust outlined 31 strategic risks of which eight referred to estates issues. We found that overall executives and non-executive directors were conversant with the BAF. However, we were told that the audit and risk committee reviewed the BAF quarterly and that the board reviewed it every six months, which appeared to be insufficient scrutiny. We were also told that the BAF was subject to further development and that it had last had a major overhaul in 2016. We found on examination of the BAF document that action owners and timeframes for completion were not clearly identified. We also found that some risks, for example, those shown as extreme, did not have sufficient detail on how board assurance would be gained or what the gaps in assurance were. The BAF did not always clearly link risk to strategic objectives. For example the BAF quoted a risk of not having a strategic estates plan covering both sites but the trust strategy only focused on the aim to achieve an acute treatment centre on an adjacent university site. We made these findings independently from an external audit report (Desktop review of responses to Well-led, issued in March 2018) which found similar issues.

In contrast to the BAF, the corporate risk register was clearly set out, gave clear descriptions of risks, was specific about the areas of the trust affected; identified clearly the owners of the risk; described the controls that were in place and also clearly described the gaps in those controls as well as identify action already taken and timescales for action in progress. As such it gave a clearer picture of assurance than did the Board Assurance Framework.

Non-executive and executive directors were clear about their areas of responsibility. The Board of Governors previously had not been holding non-executive directors to account but had started to exercise their role of challenge more vigorously following an away day when they became clearer about their responsibilities. The non-executive directors were described as very skilful and worked together well with the board, providing effective challenge. Although when asked, executives and non-executives were clear about their own responsibilities, we were unable to find a single document which clearly set out their individual responsibilities so that we could be assured that all aspects of the trust’s functions were covered. For example we saw a board paper of March 2018 which outlined individual membership of the various committees of the board. Individuals were named by their initial and surname only and not by job title or identification if they were an executive or non-executive director. While individuals within the board might be clear, this was in a public facing board paper and external person would have difficulty identifying actual individual responsibilities.

Although we saw discussion of mental health issues in various individual board papers for 2017 and into 2018 and reference to CQC recommendations that trusts provide solutions to the range of issues we set out for people with mental health conditions or a learning disability across national bodies, we did not see one cohesive document either in the annual report or in the trust strategy
that brought all of this together. We were therefore not assured that robust governance arrangements were in place in relation to Mental Health Act administration and compliance other than on a piecemeal basis. The overall accountability for cohesive provision for people with mental health needs remained unclear. We were not assured therefore that, the governance framework was sufficiently detailed to address the need to meet people’s mental health needs.

A clear framework set out the structure of ward, team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to take action as needed. The trust was divided into four clinical directorates each led by a triumvirate of divisional director, clinical director and director of nursing. Business is conducted and performance monitored by regular divisional team meetings reporting up to the board via the Chief Operating Officer. Non-executive directors were clear in describing to us he process whereby risks were escalated through the organisation via trust management and executive and divisional meetings and performance reviews. However from our review of minutes of the quality and safety and audit and risk committees there was a lack of clarity from those minutes of decisions taken to escalate specific issues to the board.

The trust was working with third party providers effectively to promote good patient care. This was done through engagement with the local External Services Scrutiny Committee; engagement with local Healthwatch; consultation with the trust Council of Governors; through holding regular People in Partnership forums to enable the trust to listen to the views and opinions of the communities they serve; voluntary sector organisations; engagement with user and support groups; local CCGs and NHSi and NHSE. In addition the trust was a member of the Hillingdon Accountable Care Partnership which aimed to bring together the local GP confederation, social services, voluntary sector and adjacent health trusts to promote greater integrated care in the local community.

A partnership arrangement was in place for the provision of psychiatric liaison services with a neighbouring mental health trust and with appropriate governance arrangements.

<table>
<thead>
<tr>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial metrics</strong></td>
<td><strong>Previous Financial Year (2015/16)</strong></td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td>£238,707,000</td>
</tr>
<tr>
<td><strong>Surplus (deficit)</strong></td>
<td>(-£1,488,000)</td>
</tr>
<tr>
<td><strong>Full Costs</strong></td>
<td>(-£240,195,000)</td>
</tr>
<tr>
<td><strong>Budget (budget deficit)</strong></td>
<td>£0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

In the last financial year the trust’s planned deficit was £8.7 million. It achieved slightly better at £8 million deficit but this included £600 k winter pressures fund which went into its bottom line accounting.

Whilst the trust delivered on its financial target, this was largely dependent on one off items which masked an underlying deterioration in finances overall – largely brought about by increasing...
demand. Recognising that additional support was needed to recover the trust’s financial position, the trust board has been working with NHS Improvement to deliver a financial improvement programme.

The trust board took the decision that it could not agree their control total with NHS Improvement in September 2016, which had they done so could have placed them slightly in surplus. However, they did not feel that they could achieve their control total.

**Management of risk, issues and performance**

The trust provided a summary document detailing the contents of their health and care risk register. This was not the actual corporate risk register which was more detailed:

<table>
<thead>
<tr>
<th>Reference</th>
<th>Subject</th>
<th>Previous</th>
<th>Residual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>The Management of Legionella and Pseudomonas in Trust Premises</td>
<td>15 (18/04/2016)</td>
<td>20</td>
<td>8</td>
</tr>
<tr>
<td>190</td>
<td>Tower &amp; Podium Mains Electrical Distribution Panel, Sections A, B &amp; C</td>
<td>9 (24/02/2016)</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>132</td>
<td>ICT Communications Rooms Air-Conditioning Infrastructure at HH and MV</td>
<td>4 (11/11/2016)</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>450</td>
<td>Ventilation in ITU</td>
<td>9 (24/02/2017)</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>665</td>
<td>Lack of capacity</td>
<td>20 (18/04/2017)</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>733</td>
<td>Underlying Financial Performance 2017/18</td>
<td>n/a</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>736</td>
<td>Delivery of non-invasive ventilation outside of the Intensive Care Unit.</td>
<td>n/a</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>652</td>
<td>White notes not filed in main patient notes in a timely manner</td>
<td>n/a</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>672</td>
<td>Multiple sources for recording and managing patient clinical indicators</td>
<td>n/a</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>399</td>
<td>Nursing staffing levels in the Trust</td>
<td>16 (26/02/2016)</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>445</td>
<td>The Management of Legionella and Pseudomonas at the MVH site</td>
<td>9 (13/07/2017)</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>544</td>
<td>Management of Control of substance Hazardous to Health (COSHH) Risk assessments.</td>
<td>6 (22/08/2017)</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>569</td>
<td>Failure/delay in escalation of deteriorating patients</td>
<td>n/a</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>149</td>
<td>Containment of Fire</td>
<td>8 (10/08/2017)</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>151</td>
<td>Provision of Emergency Lighting</td>
<td>9 (29/03/2016)</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>335</td>
<td>High Dependency Care for Children</td>
<td>20 (18/01/2016)</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>551</td>
<td>Medicine Storage</td>
<td>n/a</td>
<td>10</td>
<td>4</td>
</tr>
</tbody>
</table>
The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The governance team regularly reviewed the systems. The non-executive directors were closely involved in investigation of serious incidents. All of the investigation reports we saw contained an action plan to capture learning. The action plans differed in format, some containing timescales for completion and some not. In addition some action plans had been updated with actions and some updates were missing on others.

With reference to safeguarding we found that there was no effective governance in place to ensure patients subject to deprivation of liberty were reviewed, with the result that we found evidence of patients where a DoLS order had expired. There was no allegations policy in place. The trust did not always receive Section 42 reports from the local authority which meant that learning was not always shared. We found also that the trust safeguarding team was reliant on temporary staff to supplement the substantive lead nurses. We found that there was a safeguarding adult committee and a separate safeguarding children committee. The Director of Nursing and Patient Experience was the executive lead for safeguarding children and adults and they and the named doctor, named nurse and head of adult safeguarding were all actively...
involved in safeguarding. However in addition to the lack of an allegations policy there were other gaps including the lack of oversight from the safeguarding team due to a lack of involvement of patients in investigations and acting on the principles of Making Safeguarding Personal. There was an annual safeguarding report to the board from the Safeguarding Committee.

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance. The trust board attempted to provide assurance that the trust’s statutory obligations as well as its overall performance was of the standard expected or that action was being taken to try to achieve compliance to those standards. It did this either directly or through its committee structure comprising of an audit and risk committee, quality and safety committee, capital investment committee, board of directors nomination committee, board of directors remuneration committee and charitable funds committee. Apart from the board which met 12 times in 2017 (though for 2018 this was changed to bi-monthly) the committees that met most frequently in 2017 were the quality and safety committee which met five times, and the capital investment committee which met nine times. The quality and safety committee met to focus on the challenge to ensure that the trust continually transformed its services via four main work streams of responsible accessible care; emergency care improvement; accountability, and workforce. The capital investment committee, comprising of four executive and four non-executive directors, met with the aim of shaping, challenging and reviewing the development and implementation of the trust’s strategic redevelopment plan.

The other committees of the board met between one and four times in 2017. All committees provided periodic reports to the board. Of note is the Transformation Committee which focused on transformation schemes to improve quality while reducing cost. This met four times in 2017.

The trust told us that they were one of seven trusts selected to take part in a programme run by NHSi which aimed to deliver a lean management structure as well as ways to allow staff and patients to improve their own processes and ways of working.

Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. Such information was provided to the board, its committees and the managers by the trust’s clinical governance team, who collected and maintained an overview of quality information. This included quality indicators as part of an integrated quality and performance report, information from clinical audit; clinical incidents, serious incidents, complaints and claims.

Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed. Staff concerns matched those on the risk register. Robust arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. The trust board had sight of the most significant risks and mitigating actions were clear. The trust corporate risk register was clearly set out and demonstrated a systematic approach to risk.

The clinical governance team explained the process whereby locally reported risks identified and reported by staff were documented. They were graded by clinical governance staff using a scoring matrix. Those risks which were either high score or could not be resolved locally were reported and escalated to the corporate risk register via divisional governance boards and trust committees such as the patient safety committee; health and safety committee; information governance steering group as examples and as part of the trust’s risk management strategy and policy.
There were plans in place for emergencies. - for example adverse weather, a flu outbreak or a disruption to business continuity. The trust had an emergency preparedness plan and a team to support staff to ensure an efficient and effective response to a wide range of incidents and emergencies in accordance with the Civil Contingencies Act (2004). Each area of the trust had a nominated lead for emergency planning and there was a Head of Emergency Preparedness and Business Continuity reporting to the trust board via the chief operating officer. There was also coordination with other hospitals and emergency services in planning for and managing all types of significant and major events, including any incidents at Heathrow airport where Hillingdon hospital was the nearest NHS hospital to handle casualties. One recent example was this trust providing beds for intensive care patients from a neighbouring trust to enable that trust to take in patients from the Grenfell Tower fire in June 2017.

The emergency preparedness plan was on the trust intranet for reference. There were also hard copies of the plans on the wards some of which were out of date. We were told that because amendments were frequent it was not possible on a cost basis to keep updating the hard copies although the action cards for staff on the wards remained the same and did not need updating. We raised this as an issue with the trust chief executive.

Where cost improvements were taking place there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability. Where such cost improvements were taking place, the trust took steps to ensure that they did not compromise patient care. The trust Transformation Committee which focused on transformation schemes to improve quality while reducing cost aimed to ensure that patient care was not compromised. This met four times in 2017.

**Information management**

The board received holistic information on quality and sustainability. Leaders used meeting agendas to address quality and sustainability sufficiently at all levels across the trust. Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Information on quality was supplied to the board, its committees and management team by the information and clinical governance teams. The trust information team had undertaken a triangulation exercise in 2017, examining data sources that they regularly analysed for potential underlying issues of quality related to performance or quality. This was to assist the trust and trust board to be clear on its priorities and quality targets. The board and senior staff expressed confidence in the quality of the data and welcomed challenge. They told us in interview that they felt well aware of risks, priorities and areas of development provided by the information they received. The board used its system of quality performance management to assess its performance in relation to regional and national comparators for key quality indicators.

Staff said they had access to all necessary information and were encouraged to challenge its reliability. There were different means available to them to do this either by one to one and team meetings; responding to regular trust information bulletins; via freedom to speak up guardian who reported dealing with operational issues; raising concerns at work; via the dignity at work and grievance policies, and speaking in confidence escalating their concerns to their manager or above.
The trust was aware of its performance through the use of KPIs and other metrics. This data fed into a board assurance framework. Quality and safety information and intelligence as presented to the Quality and Safety Committee bi-monthly along with a summary of performance against KPIs, with appropriate escalation to the board as required. A good level of financial information was available at board and sub-committee level, with a clear statement of the financial position of the trust. The senior staff we interviewed told us the financial and CIP reporting highlighted key risks and appropriately set out the current position, which allowed robust conversation at board and sub-committees on mitigations and future delivery.

Information was in an accessible format, timely, accurate and identified areas for improvement. Systems were in place to collect data from wards and teams and this was not over burdensome for front line staff. Trust board members told us that they were confident in the submission of timely and accurate information to access performance and risk. Where there were incidents of inaccurate reporting these had been identified and actions taken to remedy the inaccuracies, for example the lack of electronic records in gastroenterology and the move towards achieving them and also inaccuracies that had been found in the recording of incomplete patient pathways.

IT systems and telephones were working well and they helped to improve the quality of care. Staff had access to the IT equipment and systems needed to do their work. During the previous financial year, the trust invested in a capital programme of £10.9 million on the facilities, equipment and technology used by staff for information and to deliver healthcare. The transformation committee examined the use of technology to improve service provision and an example was a business case to purchase electronic recording devices to improve patient response rates to patient surveys particularly in urgent and emergency care. Leaders submitted notifications to external bodies as required. This included incident and serious incident reporting under the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (STEIS). In its latest annual report the trust reported one information governance category 2 breach following the theft of a trust encrypted laptop containing patient data. This was investigated by the Information Commissioner who found non-adherence to trust policies and procedures to safeguard information. Information governance systems were in place including confidentiality of patient records. The trust learned from data security breaches. The Information Commissioner recommended that in this particular case the trust add an explicit paragraph on working in the community in its code of conduct for employees regarding its confidentiality policy.

The trust had completed the Information Governance Toolkit assessment. An independent team had audited it and the trust took action where needed. The trust’s information governance report overall score for 2016/17 was 82% and was graded green. This was rated as satisfactory with all requirements level 2 or above – on a scale of 0-3.

**Engagement**

The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives. The director of patient experience and nursing had board responsibility for engagement with patients and their carers. The trust offered governors training on appointment. They were actively involved in the operation of the trust. The trust
governors had recently become more proactive in their engagement and challenge to the trust following an away day following which they better understood their role.

The trust with the council of governors updated and approved the Membership Development and Engagement Strategy in February 2016. The main aims of the strategy were to encourage governors to attend local community groups and events; attract new trust members via monthly governors’ surgeries in the two hospitals; encourage the signing up of friends and families, as well as encouraging membership via inserts into appointment letters; and to utilise the overlap between the functions of the governors with other consultative and representative groups.

The trust sought to actively engage with people and staff in a range of equality groups. The trust stated its commitment to recruiting patient and carer members, and thereby obtain views and engagement, from the diverse population it serves and to target any group which might be underrepresented such as young people between the ages of 16 and 39.

The ward, team and division had access to feedback from patients, carers and staff and were using this to make improvements. Feedback included: 89% of patients thought there was enough privacy when treated or examined; 81% reported call buttons being answered within five minutes; 81% said that anaesthetists or other staff explained how the patient would be put to sleep or have pain controlled; 93% said the room/ward was very/fairly clean; 93% said that the hospital toilets were very/fairly clean; 79% rated care seven plus out of ten, and 79% said that overall they were treated with respect and dignity.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used. The trust published a quarterly Pulse magazine which was also on the intranet where there were also regular updates for patients in the latest news section.

Patients, carers and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The trust was better than the England average for the percentage of patients recommending the service in the Friends and Family Test. In 2016 the trust performed well in the national staff survey with above average results in 17 out of 32, and of these, 12 were ranked in the top 20 per cent of all acute trusts in England.

Divisional leaders, on behalf of front line staff, engaged with external stakeholders such as commissioners and Healthwatch. The trust was actively engaged in collaborative work with external partners, such as involvement with the North West London sustainability and transformation plan (STP). The trust was a member of the Hillingdon Accountable Care Partnership in collaboration with a local mental health trust; a consortium of GPs; local social services; the local CCG and local voluntary groups whose first project was to improve integration of care, health and social services for those aged 65 and over.

External stakeholders said they received open and transparent feedback on performance from the trust. All commented fully on the trust’s achievements in the trust’s annual report indicating that they had been kept fully informed by the trust.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months. In relation to complaints we saw improvements from the last inspection and a more robust system which used tracking templates
and there was evidence not only of timely responses. These included appropriate clinical input and apologies and most, but not all, set out clearly lessons learnt and actions taken.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>90%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>30</td>
<td>90%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>45/60</td>
<td>90%</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>1,211</td>
<td>n/a</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

The trust received 467 complaints from November 2016 to November 2017; surgical care core service received the most complaints with 165. The biggest complaint subject was all aspects of clinical treatment – surgical group with 84 complaints, followed by attitude of staff with 51 complaints.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC – Surgery</td>
<td>165</td>
<td>35%</td>
</tr>
<tr>
<td>AC - Medical care (including older people’s care)</td>
<td>88</td>
<td>19%</td>
</tr>
<tr>
<td>AC - Urgent and emergency services</td>
<td>74</td>
<td>16%</td>
</tr>
<tr>
<td>AC - Outpatients</td>
<td>57</td>
<td>12%</td>
</tr>
<tr>
<td>AC - Maternity</td>
<td>38</td>
<td>8%</td>
</tr>
<tr>
<td>AC – Diagnostics</td>
<td>21</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>4%</td>
</tr>
<tr>
<td>AC – Gynaecology</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td>AC - Services for children and young people</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>AC - End of life care</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Provider wide</td>
<td>467</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Learning, continuous improvement and innovation

The trust actively sought to participate in national improvement and innovation projects. The trust stated the intention of strengthening the relationship with local academic partners, such as the local university, as well as with an academic health service network hosted by another London NHS trust, with the aim of creating an environment of innovation at the trust. The trust’s target savings from its Quality Innovation Productivity and Prevention (QIPP) plan for 2016/17 was £9.6 million.

Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented. Staff were encouraged through the trust’s Bright Ideas scheme to submit
ideas and activities for improving the quality of the workplace and patient care. This was promoted through email and via the trust bulletin on the intranet.

The trust had a planned approach to take part in national audits and accreditation schemes and shared learning. The trust had a comprehensive clinical audit plane covering both national and local audits. This programme was reviewed each year particularly in relation to local clinical audit. During 2016/17 the trust participated in 36 national clinical audits and four national confidential enquiries. It also ran 84 local clinical audits during the same period. Learning from clinical audits was discussed at each Quality and Safety committee and disseminated to ward level via intranet and divisional meetings.

The trust was participating in clinical research studies. The trust’s main research activity was recruiting patients into National Institute for Health Research (NIHR) portfolio multi-centre trials. During 2016/17 the trust has approximately 65 NIHR portfolio studies open or in follow up and the trust had recruited 713 patients into 41 trials.

There were organisational systems to support improvement and innovation work. The trust told us that substantial progress had been made in integrated systems working with social care and primary care partners and now enhanced by the formation of the Hillingdon Accountable Care Partnership.

Effective systems were in place to identify and learn from unanticipated deaths. The trust tracked HSMR monthly and had a mortality surveillance group reviewing deaths occurring in its hospitals. The trust had aligned its mortality review processes in line with the NHS England Framework on Learning from deaths published in March 2017. This covered roles and responsibilities, governance arrangements and reporting requirements.

Although we were told that staff were encouraged to think about innovations and improvements, we could find no direct evidence of protected time being given for this.

External organisations had recognised the trust’s improvement work. Individual stakeholders commented in the latest trust annual report and accounts that they had noted improvements, for example in NEWS compliance, improvements in provision of seven day working, compassionate care and also commented that the trust still needed to make improvements in some areas such as urgent and emergency care, and staff recruitment and retention.

Individual staff and teams received awards for improvements made and shared learning. There was a trust annual awards ceremony and individuals had also received external awards for work and innovation in such areas as raising awareness of Female Genital Mutilation; excellence in health education, and information technology.

Staff were aware of their contribution to cost improvement objectives. The Director of Finance told us that when he joined the trust, staff understanding of the financial situation of the trust and their contribution to improvements was poor but was now improving. Cost reduction schemes achieved by staff included electricity tariff renegotiation, water leakage detection and saving, reducing agency staff reliance and spend, and more effective use of internal facilities and repairs services.

Staff used data to drive improvement. Clinical divisions reviewed their data in relation to patient safety, patient experience and clinical effectiveness on a monthly basis. Human resources used data to monitor and control sickness absence. Staff used data to examine incidents and statistics around bullying and for reviewing equality and diversity measures. The trust Data Quality
Improvement Steering Group’s remit was not only data improvement but also reporting on risks to data quality within the trust.

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
</table>
| Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189 | CPA status  
Biochemistry - 31/01/17  
Microbiology - 29/05/15  
Cellular Pathology - 22/11/17  
Please note: the laboratories have not undergone ISO15189 accreditation yet. |
| MacMillan Quality Environment Award (MQEM) | MacMillan Cancer Information Centre at Hillingdon (March 2015) |

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).
Acute services

Urgent and emergency care

Facts and data about this service

The Trust has a range of urgent and emergency care services based at two sites within the borough:
- Hillingdon Hospital
- Mount Vernon (minor injuries unit) - not being inspected in this current inspection

The emergency department is co-located alongside the urgent care centre at the Hillingdon Hospital site. It is open 24 hours per day seven days per week and sees approximately 129,000 patients a year, which is an increase from 85,000 patients in 2013. The adult department has the capacity to care for patients in 27 trolley or bed spaces across three areas. Alongside the emergency department and the urgent care centre is a separate dedicated paediatric emergency department designed specifically for the needs of younger patients. Both the paediatric and adult emergency departments are consultant led.

The emergency department is divided into four key areas:
- The four bay resuscitation area for the most seriously ill or injured patient.
- The majors area for the assessment and treatment of major illness.
- The paediatric emergency department which sees all patients up to the age of 16.
- The clinical decision unit (CDU) which accommodates seven patients in beds and five seated patients who require planned interventions and treatments for a period of no more than 12 hours to help facilitate the discharge of those patients that don’t require admission.

The urgent care centre is run by another healthcare provider and is designed to see patients that have an urgent condition or minor injuries.
There is a minor injuries unit based at another site at Mount Vernon Hospital (approx. seven miles away from the ED) which sees approx. 24,000 patients a year and which was not inspected. The MIU is staffed and lead by emergency nurse practitioners and is open from 09:00 to 20:00 seven days a week apart from Christmas day when it is closed.

Total number of urgent and emergency care attendances at The Hillingdon Hospitals NHS Foundation Trust compared to all acute trusts in England.
There were 162,310 attendances from April 2016 to March 2017 at The Hillingdon Hospitals NHS Foundation Trust as indicated in the chart above.
Urgent and Emergency Care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission fell from 2015/16 to 2016/17. In 2016/17, rates were lower than the England average.

Urgent and Emergency Care attendances by disposal method

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training
The trust set targets between 80-95% for completion of mandatory training.

A breakdown of compliance for mandatory courses from April 2017 to November 2017 for all staff in urgent and emergency care is shown below:
### Training module name

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained (YTD)</th>
<th>Number eligible (YTD)</th>
<th>Completion (%) YTD</th>
<th>Target Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Induction</td>
<td>80%</td>
<td>65</td>
<td>72</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>80%</td>
<td>238</td>
<td>266</td>
<td>89%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>80%</td>
<td>234</td>
<td>266</td>
<td>88%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>80%</td>
<td>234</td>
<td>266</td>
<td>88%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety (two years)</td>
<td>80%</td>
<td>148</td>
<td>183</td>
<td>81%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>80%</td>
<td>213</td>
<td>266</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (level one)</td>
<td>90%</td>
<td>24</td>
<td>30</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>80%</td>
<td>177</td>
<td>230</td>
<td>77%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>204</td>
<td>266</td>
<td>77%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (level two)</td>
<td>90%</td>
<td>178</td>
<td>236</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>80%</td>
<td>154</td>
<td>222</td>
<td>69%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>80%</td>
<td>28</td>
<td>44</td>
<td>64%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety (three years)</td>
<td>80%</td>
<td>42</td>
<td>81</td>
<td>52%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>1939</strong></td>
<td><strong>2428</strong></td>
<td></td>
<td><strong>80%</strong></td>
<td></td>
</tr>
</tbody>
</table>

During the last CQC inspection in May 2015, we noted that mandatory training figures were poor at 50% against an 80% target. Data up to November 2017 illustrated above showed that seven out of 13 mandatory training modules failed to meet the trust target. Fire safety (three years) had the lowest completion rate of 52% compared to the trust target of 80%.

Data submitted following the inspection showed that overall compliance with mandatory training was at 88% although CQC was not provided with a breakdown of this.

Data submitted by the trust for Adult ED nursing staff confirmed that 12% of nursing staff were either advanced paediatric life support (APLS) or European paediatric life support (EPLS) trained and 14% were advanced life support (ALS trained). We were also told that whilst intermediate life support (ILS) and paediatric intermediate life support (PiLS) were delivered in-house, it was not monitored and there was no record of compliance.

We were told during the inspection that 80% of paediatric nursing staff were trained in either EPLS or APLS. However, the trust submitted data which was at variance with this and indicated that 54% of all nurses in charge were APLS or EPLS trained. There was no record of compliance with ILS or PiLS since it was delivered in-house and not recorded electronically.

Data confirmed that 100% of shifts were covered with at least one APLS trained nurse.

We were told that sepsis training was covered during trust induction training and there was 100% compliance for all staff who worked in ED majors and paediatric ED.

Data showed that 100% of paediatric consultants and paediatric registrars were trained in APLS. 100% of senior house officers and trainees were trained in PLS. In addition, we were told there was a weekly simulation programme and a monthly multidisciplinary high-fidelity simulation programme led by consultants.

### Safeguarding
The trust set targets between 80-90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April 2017 to November 2017 for all staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained (YTD)</th>
<th>Number eligible (YTD)</th>
<th>Completion (%) YTD</th>
<th>Target Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (level 1)</td>
<td>80%</td>
<td>233</td>
<td>266</td>
<td>88%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (level 1)</td>
<td>90%</td>
<td>236</td>
<td>266</td>
<td>89%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (level 2)</td>
<td>90%</td>
<td>209</td>
<td>236</td>
<td>89%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (level 3)</td>
<td>90%</td>
<td>91</td>
<td>111</td>
<td>82%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td></td>
<td><strong>769</strong></td>
<td><strong>879</strong></td>
<td><strong>87%</strong></td>
<td></td>
</tr>
</tbody>
</table>

Three out of four safeguarding training modules failed to meet the trust target. Safeguarding Children (level three) had the lowest completion rate of 82% compared to 90% trust target. However, training records for nursing staff in the paediatric ED showed there was 95% compliance with Safeguarding Children (level 2) and 88% compliance with Safeguarding Children (level 3). Female genital mutilation (FGM) training was incorporated into safeguarding training and staff told us they were aware of it although had not yet come across it in patients.

Subsequent data supplied by the trust for March 2018 demonstrated an improvement in safeguarding children training at all levels; level 1 was 94%; level 2 was 94% and level 3 was 91%. However, it was not clear from the way in which data was supplied by the trust whether training was low for individual staff groups.

The Counter Terrorism and Security Act 2015 introduced the Prevent duty for various bodies. The Prevent duty's aim is to help stop vulnerable people from being exploited and drawn into terrorism. We were told that there was 80% compliance with Prevent training.

Staff told us they were confident in their knowledge of the trusts safeguarding procedures and how to use them. They told us they would not hesitate to escalate any concerns they might have about patient safety. There were 31 referrals made by ED staff to the safeguarding team between March 2017 and February 2018. There was a total 576 referrals made by ED staff to the safeguarding team between March 2017 and February 2018. Thirty one of these referrals were for adults and 545 were children.

**Cleanliness, infection control and hygiene**
Similar to our findings in the last CQC inspection in May 2015, we found there to be a very poor level of cleanliness, infection control and hygiene throughout the general ED area.

We were not inspecting the streaming service which was run by an independent provider. However in some instances, we noted there was poor infection prevention control practice which carried a high risk of cross infection. For example, there was limited hand decontamination carried out between patients and no obvious cleaning of equipment such as the oxygen saturation probe. We saw a mother placing their toddler on the ledge to be assessed by the nurse; this child was reported to have diarrhoea and vomiting. Once examined, there was no obvious decontamination of the area where the child was and the next patient queueing up was seen as soon as the toddler was removed.
The area in which patients were assessed once streamed, the early first assessment and management (EFAM) area had litter on the floor and dried blood on a wall and curtains.

We observed several instances where bays in the ED majors area were not cleaned between patients. Ambulance crew told us they often had to do their own cleaning before they moved their patient into the allocated bay. We noted that the bay to which ambulance patients were first taken to be triaged (pitstop) was not always cleaned between patients.

Hand hygiene between patients was not always evident; there was a hand wash basin available and hand gel in all cubicles. During one particularly busy period, we observed little hand washing done by doctors between patients.

The floor of the resuscitation room looked dirty and had many marks on it. The blood gas machine in bay two of the resuscitation area had dried blood in the port area. This was evident on two inspection days, with additional blood noted on the second day. There were blood spatters on the wall adjacent to the blood gas machine on both days.

Other equipment which was visibly unclean included a portable scanner, resuscitation trolley and monitor, all of which were dusty. There were six blue procedure trays, all of which were visibly dirty with blood spatters on some. There were four blood pressure cuffs two of which were soiled and did not appear to have been cleaned between patients.

Plastic aprons were not readily available. There was one dispenser in the resuscitation area, which was empty. We pointed this out to the nurse in charge who was unable to locate any more.

There was dust over much of the area and there were pieces of plastic discarded on top of the fluid warmer. The work surfaces were generally dusty and not clean.

The trust submitted audits of hand hygiene (HH) and bare below elbows (BBE) where the trust standard for both was 90%. The average compliance with hand hygiene between April 2017 and February 2018 was 71%. Results for December 2017 showed that compliance with HH was 56% and BBE 89%; January 2018 HH 90% and 100% BBE; February 2018 HH 75% and 100% BBE 2018. All staff we observed were compliant with bare below elbows policy. The trust did not have an action plan to address these poor hand hygiene results.

We saw several examples of poor infection control in the ED majors area. For example, hand hygiene between patients was not always evident. We checked three commodes all of which were visible dirty with faecal matter under two; all commodes had a build-up of dust and dirt on the wheels. Blue procedure trays were not cleaned and there was visible staining on top of the medicines refrigerator.

However, the dirty utility room where used equipment was stored to reduce the risk of infection and cross contamination was generally tidy and clean. All items were stored off the floor and on shelving. There were sufficient hand wash basins available, hand gel was available and staff were observed to be compliant with bare below elbows.
Patients complained to us about the level of cleanliness in the EFAM area and ED majors in particular. One said “The cleaner was here twice cleaning the floor and the sink and the sink still has dirty marks and lots of lime scale.”

The paediatric ED was generally cleaned and well maintained. Toys in the paediatric play area were all wipe clean and cleaning was part of the nightly cleaning checklist. We reviewed cleaning schedules and confirmed that cleaning was completed as directed.

Environment and equipment
The mental health interview room included a significant number of potential ligature anchor points (from which a cord could be tied to attempt strangulation) including door handles and radiator pipes. Staff told us that they would not leave a patient in this room unaccompanied by a staff member, and more frequently used this room for staff handover meetings. The most recent ligature risk assessment for the room took place in October in 2017, following which staff recommended that the room was not fit for purpose, and needed to be replaced. The mental health matron showed us a proposed new design for the interview room, to be incorporated within the main accident and emergency department.

The flooring and walls were stained and in a poor state of repair. It did not meet the standards expected of a place of safety for patients with mental health difficulties. There were two doors to enter or leave the room. Doors to the room were not anti-barricade doors, and furniture was not safe in the event of challenging behaviour. There was no clock available, to orientate patients using this room, and the temperature of the room could not be adjusted. There were also no toilet facilities close to the room, so staff had to accompany patients to the A&E toilets when needed. There was no fixed alarm in the room, but staff carried portable alarms.

Staff told us that the site of the mental health interview room in ED was outside of the main department and was isolated from areas where other clinical staff were. For this reason they used it infrequently and instead often used cubicles in the ED department. Staff advised that patients who required a place of safety were transferred by ambulance to the nearby mental health trust place of safety as soon as possible.

The care of psychiatric patients in ED was placed on the risk register in June 2011 and updated in December 2017. However, the reasons for being on the risk register did not refer to the poor safety and physical condition of the room. Instead, reference was made to the isolated location of the room and the almost daily occurrence of abuse or violence and ‘abusive or violent patients are often frightening for other patients and staff; management of these patients is time consuming and resource intensive.’

There were no sepsis trollies available in any part of the ED area.

The ED areas had a folder which contained all the routine safety checklists which should be completed on a daily basis. This included the general stock list, fridge temperatures and Hypo box. The resuscitation area also included a checklist for each of the bays. We found that safety checklists were incomplete. However, we saw that all checks for resuscitation trollies were complete. We were unable to break the seal and inspect the contents of these trollies as we did not want to take busy nursing staff away from patients to do this with us.
Checks of the general stock checklist for essential stores and supplies were incomplete on several occasions between January and March 2018. Checks were not completed on 14 days in January; 20 days in February and no checks between 01 and 04 March. Similar checks in the resuscitation bays were also incomplete for all four bays for 18 days in January; 12 days in February and three days up to 08 March.

The area in which patients were assessed once streamed, namely the early first assessment and management (EFAM) was in a small room with two bays separated by a wall and with curtains on each. This space was cluttered with boxes stacked on the chute which sent bloods to the pathology laboratory. The chute basket contained gowns, wipes, spare rubbish bags, slings and thermometer covers and there was damage to the wall and the floor. The temperature in one of the bays registered 28° centigrade and was noticeably hot.

The resuscitation area had four bays and bay two was poorly maintained with marks on the wall and floor. We saw that a fifth bay was created on several occasions during the inspection when the four bays were in use. The fifth space was adjacent to a storage area and an exit to the corridor. It was not an equipped area; portable screens were used to shield patients and we noted these portable screens were in poor repair and in some cases, held together with medical tape. There was no piped oxygen or suction and no curtains to protect the patient’s privacy and dignity.

There was no formal protocol around the use of the fifth bay. The trust told CQC the decision to increase to a fifth bay when the four were occupied was made by a consultant or by the registrar in charge in the absence of a consultant. The bay was used only when there was a mobile monitor available. Priority would be given to stable patients waiting for transfer to a ward when there is no space in ED majors for them to go to.

The environment in the minor injury area of ED was very busy, at times overcrowded and difficult to access cubicles to do full checks. Cubicles were very small, with patients on trolleys less than one metre apart in some cases leaving no room for privacy of conversation or assessment. There was a chair space for patients who could sit positioned next to the filing cabinets at the work station and another beside one of the hand wash basins, again affording little or no capacity for privacy.

The store room, which was accessed via a patient bay was chaotic and disorganised; there were boxes and equipment stored on the floor. There were two grab bags which contained sterile single use items that were out of date. There was also a laryngeal mask with an expiry date of May 2017; out of date syringes and IV giving sets in damaged packaging. Patients told us they found much of the environment in the ED department to be cramped. One said, “staff are working on top of each other, there is no room for them to move.” All sharps boxes we inspected in the resuscitation area and ED majors were assembled and labelled correctly and were not over full.

The eye room appeared to be used as both a store room and as an extra patient cubicle. It was cluttered and had a number of boxes stored on the floor; we saw a patient remained in this room overnight.

The paediatric ED (PED) was opened in July 2016. Patients were not taken directly to the PED. Instead, they were initially streamed along with all other patients by the independent healthcare provider, who were not paediatric trained nurses. The PED included a four bedded paediatric assessment unit which was operated by the paediatrics service and was not part of this inspection
of the ED department. There was a high dependency room which we were told was not fully operational but at some point, should funding permit, this would be used as a paediatric resuscitation bay. In the meantime, children who required resuscitation were taken to the fifth bay in the resuscitation area of ED majors.

PED had six individual cubicles for patients and a play area which had a gate and low fence around it. We found the environment throughout PED to be visibly clean and tidy; it was bright and airy with child appropriate décor. There was secure access via an intercom system. All equipment was new and in a good state of repair. We found that most equipment was regularly checked; however, we noted that there were 17 occasions between December 2017 and February 2018 when the resuscitaire was not checked.

We saw an audit of equipment used in ED, which confirmed that all were within service date.

**Assessing and responding to patient risk**

The urgent care centre was run by an independent health care provider and was designed to see patients with an urgent condition or minor injuries. All patients, including children were streamed by an independent provider nurse who then streamed them to different areas which included the urgent care centre or to the trust early first assessment and management (EFAM) which was an enhanced nurse and consultant lead triage system based in two triage rooms. CQC requested performance data separately from the independent healthcare provider as this was not held by the trust. This demonstrated that between September 2017 and February 2018 99% of adult patients were streamed within the target 20 minutes and 98% of paediatric patients were streamed within the target 15 minutes.

Many staff told us there was no clinical oversight of patients in the general waiting area once they had been streamed and were waiting to be seen. They had concerns that a deteriorating patient would not always be noticed. Members of the divisional leadership team told us they hoped to work with the independent healthcare provider and develop training for their staff in recognition of the deteriorating patient.

Ambulance crews told us their responsibility to the patient ended once the patient was transferred onto a hospital trolley. However, this process did not always happen quickly; in which case, they returned to the corridor with the ambulance crew once the patient was seen in the ‘pitstop’ for what could be in excess of an hour before getting a hospital trolley. Ambulance crew told us the system was inefficient at times; they were not always made aware of the wait time and they told us they frequently re-joined the queue (post-pitstop queue) in the corridor once the patient had been assessed in the pitstop whilst a bay was found for the patient. During this time in the queue, ambulance crew told us there were no further observations made of the patient and they were unclear as to whose responsibility the patient was. However, an ED manager told us that ambulance crew were expected to do observations of a minimum of every 30 minutes.

Once they were transferred to a hospital trolley in a bay, no updated handover took place between the ambulance crew and ED staff. At this stage, there was no oversight of what may be a deteriorating patient and there could be waits in excess of four hours before they would be seen by a doctor.
We were told that where staffing permitted, a nurse was allocated to the corridor to monitor the patients there but this was more the exception rather than the rule.

We observed one patient who arrived to the resuscitation in an unresponsive state. They were taken to the fifth bay which lacked piped oxygen or suction. We noted that no members of trust staff were available to meet this patient as they were involved with other patients; in the meantime, there was no monitoring of this unresponsive patient. They were transferred from the ambulance trolley to the hospital trolley some 20 minutes later and a mobile defibrillator and some screens were taken to the bay.

We found the time to first set of observations in the minor injuries area was particularly poor. With the exception of one patient whose observations were done at 11 minutes, the remaining five patients had their first set of observations done between two and five hours.

Emergency Department Survey 2016

The trust’s scored “about the same” as other trusts for four of the five Emergency Department Survey questions relevant to safety. The trust scored “worse than” other trusts for the remaining question “In your opinion, how clean was the emergency department?”

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>7.4</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Median time from arrival to initial assessment (emergency ambulance cases only)

Emergency ambulance crews which travelled under a blue light pre-alerted the emergency department (ED) to their arrival. This in turn triggered a blue light in different parts of the ED and the patient was taken straight to the resuscitation area and booked in by ambulance crew once they handed the patient over.

Where it was not a blue light, and the patient was on a trolley, the ambulance crew booked the patient in at a window close to the ambulance bay which is managed by the trust. They then waited with the patient in the corridor for an assessment in the ‘pitstop’ before going to ED majors or back to the urgent care centre.

Patients who were in a chair or were ambulant were taken to the booking in window at the front of the hospital run by the external provider. Ambulance crews told us they found this part of the booking in system confusing and not wholly efficient.
The median time from arrival to initial assessment was better than the overall England median in all months over the 12 month period from December 2016 to November 2017. In the latest period, November 2017, the median time to initial assessment was one minute compared to the England average of seven minutes. Between February 2017 and February 2018 initial assessment took place within one and four minutes of arrival to the department.

**Ambulance – Time to initial assessment from December 2016 and November 2017 at The Hillingdon Hospitals NHS Foundation Trust**

(Original: Source: NHS Digital - A&E quality indicators)

**Percentage of ambulance journeys with turnaround times over 30 minutes for this trust**

From January 2017 to December 2017 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at The Hillingdon Hospital. In the latest period December 2017, 71% of ambulance journeys had turnaround times over 30 minutes.

**Ambulance: Number of journeys with turnaround times over 30 minutes - The Hillingdon Hospital**

**Ambulance: Percentage of journeys with turnaround times over 30 minutes - The Hillingdon Hospital**

Percentages of ambulance turnarounds over 30 minutes varied from 50% in June and September 2017 to 60% in January 2017, and followed a slight downward trend over the 12 months.
We reviewed trust data for the national standard for ambulances to handover within 15 minutes. Between March 2017 and February 2018, 33% of ambulance handovers took place within 15 minutes. Data for the local target of all ambulances to handover patients within 30 minutes was achieved 79% of the time during this same time period with a significant drop in February 2018 to 66%.

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. From November 2016 to October 2017 the trust reported 515 “black breaches”, with a downward trend over the period.

The highest number of black breaches coincided with the winter period of November 2016 to January 2017 with 390 (76%) of the black breaches took place in these three months, since then the trust have reported an average of 13 a month from February to October 2017. More recent data submitted by the trust showed that this situation had deteriorated and there was an average of 75 reported black breaches between November 2017 and February 2018.

The trust had a sepsis lead and there was also a sepsis lead in ED. We noted there were no sepsis trollies available in the department. We saw no evidence of sepsis awareness protocol or posters on display. Sepsis training was included in staff induction with no provision made for further sepsis training. Staff showed us a sepsis screening proforma which was used to screen patients with suspected sepsis.

We reviewed 13 adult and 10 paediatric patient records and saw inconsistent recognition of the possibility of sepsis. We found four paediatric records where sepsis was not considered. For example, in the case of a very young baby who presented with three high risk factors for sepsis, the reviewing consultant did not consider sepsis as a possibility and therefore tests in accordance with NICE guideline (NG51) Sepsis: recognition, diagnosis and early management were not carried out.

The ED risk register included treatment of septic patients in ED as a moderate risk and was rated six. Details on the risk register noted that Royal College of Emergency Medicine Standards for severe sepsis and septic shock were not always met and septic patients might have delays in treatment leading to unfavourable outcomes. We noted that one of the lessons learnt following a
root cause analysis of a serious incident recommended attention should be given to training junior doctors in the care of the deteriorating patient and sepsis. We saw no training data to evidence that this training had occurred.

Patients at risk of deterioration were discussed in daily safety huddles, where nurses, doctors and healthcare assistants gathered to review individual patient treatment plans and conditions. We observed one which was held at 09:30, two hours into the day shift. It was attended by senior ED nursing staff, including the director of nursing; medical staff; management staff and administrative support staff.

There was a whiteboard which gave updated information on patients within the department; a summary of the current state of the department and any points of note. These included the current longest patient wait; recent blue light calls and challenges of the day. Some of these challenges included concerns about capacity and lack of senior medical cover on the floor and in EFAM until 2pm as consultants were off site doing collective trust training. There was no discussion around how to plan to cover this absence of consultants.

Nurse staffing
The Hillingdon Hospital reported their staffing numbers below for the period April 2017 to November 2017. Nursing staff reached 88% of planned capacity as at November 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Planned Staff</th>
<th>Number in post as at November 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Hillingdon Hospital</td>
<td>124.8</td>
<td>109.9</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Nursing staff in the paediatric ED (PED) were all paediatric trained; there were occasions when agency staff were not always paediatric trained but they worked alongside the paediatric nurse on duty. Nursing staff from adult ED occasionally covered; they were familiar with the department and were well known to the paediatric team. The paediatric nursing team had a phone group chat where they could discuss shift cover; we were told that they worked as a team and supported each other to ensure there was adequate cover. We were told staffing levels were good and consisted of 16.4 whole time equivalent registered paediatric nurses and 1band 2 healthcare assistant. Trust data showed there was currently 0.5 WTE B7 vacancy and 0.5 WTE B3 vacancy.

Nurses in the paediatric ED cannulated patients, most could plaster and those nurses with more than six months experience in the department triaged patients. We were told the practice development nurse (PDN) was in the process of developing a triage competency training programme.

Trust data for ED majors showed there was a 1:2 nursing ratio in resuscitation and a 1:4 in the rest of majors. We were told this ratio was not always met in the green zone (minor injuries) due to capacity and flow issues.

Nursing ratios in PED included two nurses 24/7 for triage and cubicles and two nurses allocated 12:00 to midnight for triage and cubicles seven days per week.
There was an ED PDN available for 24 hours per week although these hours were not always fulfilled as they were often required to support the department in their active nursing role in response to pressures on the floor. We were told that there were discussions due to take place to agree a way forward to protect these hours.

Members of the divisional team told us one of their challenges was to retain nursing staff rather than spending large amounts of their budget on agency staff.

We observed a morning nursing handover which included ‘the big 4’ which was four areas identified each week which the matron asked staff to focus on. For example, on the week of this inspection staff were asked to focus on documentation; patient safety checklist; cardiac arrest forms and correct identification of patient notes. Staff were also updated on recent improvements which included availability of patient name bands and the introduction of two dementia boxes into the ED area.

We attended an evening handover which outlined the current situation in the department, and included the number of blue light ambulances on their way (11); the number of patients in the department (69); current waiting time (two hours); backlog in triage (two hours) and numbers of patients in resuscitations (five). There was a significant amount of important information shared which staff required in order to plan their shift; however, we noticed that several staff arrived late to the handover and so missed some of this information.

From December 2016 to November 2017, Hillingdon Hospital reported a vacancy rate of 28% in urgent and emergency care, compared to the trust target of 8%. These vacancies included 0.4 band 7; 0 band 6; 19 band 5 and 0 band 2/3 in ED majors and 1 band 7; 1 band 6; 0 band 5 and 0.5 band 3 in paediatrics.

During this same period, there was a reported turnover rate of 6% in urgent and emergency care for qualified nursing staff, compared to the trust target of 13%; and a sickness rate of 5% in urgent and emergency care for qualified nurses, compared to the trust target of 3%.

Urgent and emergency care had 4,017 shifts filled by bank and agency staff, which was the third highest core service uptake within the trust. Data for bank and agency usage for November 2017 was 14%; December 2017 13% and January 2018 13%. Data for paediatric ED in November 2017 was 20% and 19% in January 2018.

There was a process in place for the induction of temporary staff working in the ED including PED. There was a template for local induction checklist key information and induction requirements. This was signed off by the bank or agency nurse and the manager or nurse in charge. Once completed and signed off they were held by the matron for ED in an alphabetised folder so that staff could check easily if a bank or agency nurse received an induction. The folder was neat and well maintained. The trust was also in the process of developing and introducing an induction pack for bank and agency staff which will contain more detail on policy and procedure.

The mental health matron advised that the trust had recently recruited a bank of qualified mental health nurses, who were available to work in ED and across the hospital as needed. Staff said that they were able to access mental health nurses quite quickly and told us that the use of a social media application enabled them to arrange cover for shifts even at short notice.
The trust had a service level agreement with the psychiatric liaison team from a neighbouring mental health trust. The mental health matron was seconded from this trust, and had strong links with the psychiatric liaison team based a short distance away. They provided psychiatric nursing and consultant cover at all times.

There was a bank of registered mental health nurses (RMN) to cover shifts and provide support for patients who presented with mental health problems in the ED area. The RMNs carried out assessments and observation of patients and liaised with the psychiatric liaison team.

**Medical staffing**

The Hillingdon Hospital reported their staffing numbers below for the period April 2017 to November 2017. Medical staff reached 72% of planned capacity as at November 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Planned Staff</th>
<th>Number in post as at November 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Hillingdon Hospital</td>
<td>64.2</td>
<td>46.5</td>
</tr>
</tbody>
</table>

There were 12 consultant whole time equivalent (WTE) posts and as at March 2018 there were 10 ED Consultant posts filled with two WTE vacancies since June 2017. Middle grade doctor WTE was 16 with a 1.2 WTE vacancy carried since August 2017 and senior house officer vacancy of 4.2 WTE.

The Royal College of Emergency Medicine (RCEM) recommends there should be consultant presence in the ED 16 hours a day seven days per week as a minimum in all emergency departments. Where there is an insufficient number of consultants to meet this, risks should be mitigated by the provision of senior doctor presence (ST4 or above) 24 hours a day seven days per week.

Data submitted by the trust showed that a new ED consultant rota was implemented on 5 June 2017 which ensured there was consultant cover from 8am until midnight in the ED seven days a week. We were told there were occasions when a speciality doctor or an ST6 trainee covered the shift, with a consultant (usually the deputy divisional director) on call from home. This occurred on 3.8% of the available consultant shifts. More recently from 01 March 2018, there were 10 substantive consultants plus two speciality doctors and the deputy divisional director to ensure that the consultant rota was filled and that there was enhanced senior presence in the department.

Paediatric ED was wholly supported by resident paediatric consultants. There was an embedded model of 24/7 acute paediatric consultant-led presence for PED including overnight. This was managed with a seven consultant rota supported by three other paediatric consultants. This was in place since September 2016. Consultants based themselves in PED and supported paediatric junior doctors and ED majors doctors. Trauma support was offered by ED majors colleagues. The only gap in this service was from 8:30am hrs to 1:00pm on weekends when consultant cover was from the wards with a full complement of registrar and senior house officer support. This model was approved by the Royal College of Paediatrics and Child Health.

Paediatric consultants in the PED were acute consultants rather than paediatric emergency medicine consultants. In order to mitigate this, a doctor from adult majors ED was allocated for four hours per day to PED. We were told that this allocation did not always happen due to
demands within ED majors. We saw a reference made to this in the ED governance meeting minutes of November 2017 where paediatric doctors asked if the ED doctor could work an eight hour shift when allocated to PED. The minutes recorded stated that an extension of these allocated hours would improve on doctors’ education, exposure and training within the paediatric department.

Since the introduction of the new rota in June 2017, consultant locum cover accounted for 28%; senior house officer accounted for 41% and middle grade doctor 29%.

We were told there was no formal whole group medical team handover. The middle grades in resuscitation and ED majors area received one to one handovers whilst the rest began to see patients as soon as they reached the floor. We were told that the consultants were generally supportive though there appeared to be some confusion about the hours they were present on the department floor.

Several staff told us how the department had many agency staff working in it which meant it was difficult to have consistent leadership at times.

The area in which patients were assessed once streamed, early first assessment and management (EFAM) was staffed 24 hours per day. This included a nurse throughout the 24 hours and a middle grade doctor or consultant who was meant to be on duty between 9:00am and 12pm; 2:00pm and 10pm. However, doctors and nurses told us there were frequent occasions when there was no doctor during some of these hours as they were diverted to ED majors in times of extreme busyness.

The paediatric ED was covered by seven acute paediatric consultants 24 hours per day. From December 2016 to November 2017, Hillingdon Hospital reported a vacancy rate of 12% in urgent and emergency care, compared with the trust target of 8%.

From December 2016 to November 2017, Hillingdon Hospital reported a turnover rate of 13% in urgent and emergency care for medical staff, which equalled the trust target of 13%.

From December 2016 to November 2017, Hillingdon Hospital reported a sickness rate of 1% in urgent and emergency care for medical staff, compared to the trust target of 3%.

In September 2017, the proportion of consultant staff reported to be working at the trust as lower than the England average and the proportion of junior (foundation year 1-2) staff was lower. The trust submitted data which showed that consultant locum cover was 28% since the introduction of new roster in June 2017. Senior house officer locum cover was 41% and middle grade cover was 29%.

Locum doctors told us their induction was comprehensive and done over two days; however they also told us they were not always clear about who the consultant in charge of the department on the day was. Ambulance crew also told us it was not always apparent to them who the consultant in charge was.
Staffing skill mix for the 36 whole time equivalent staff working in Urgent and Emergency Care at The Hillingdon Hospitals NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>24%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>35%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>22%</td>
<td>34%</td>
</tr>
<tr>
<td>Junior*</td>
<td>19%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

Records
We reviewed 10 sets of paediatric patient records and found documentation was inconsistent and not always completed. For example, there was no doctor safeguarding information on nine records and no nurse safeguarding information on four records. Six records lacked any pain scores and there was inconsistent recording of paediatric early warning scores (PEWS) which included repeat observations and times were not always recorded. PEWS is a specialised tool that measures the infant/child’s clinical status and recommends an appropriate response. There was no current of PEWS and we were told they would be audited from April 2018.

However, we found records to be legible with the exception of two entries made by doctors. The child’s weight was recorded on eight and allergies were recorded on all records.

We reviewed a total of 23 patient records in the adult emergency department (six of which were patients in the minor injuries area) and found them to be disordered, not in sequence and contained multiple loose sheets, which made it difficult to pathway track patients. We noted this was raised as a concern following an audit of records in January 2018 and an incident was reported to the electronic incident reporting system due to the very poor state of a set of medical records. The information identified that progress sheets were not secured and notes were not filed in date order, which made it extremely difficult to elicit the sequence of events and treatment of a patient. The audit also stated that poorly filed notes were commonplace.
The national early warning score (NEWS) is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. Documentation was inconsistent; we found there was no NEWS recorded on seven patient records. In addition, there was no pain assessment recorded on four records and no temperature recorded on three.

**Medicines**

We found similar issues with medicine storage, equipment and temperatures checks as those found at the last CQC inspection in May 2015.

Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs and their storage and dispensing are regulated by legislation. Controlled drugs should be kept in a separate locked cupboard with those keys kept separately from the main cupboard keys; counted twice daily and when dispensed, signed by two members of staff in a separate controlled drugs register.

We inspected the storage of medicines in the resuscitation area. We were told that stock checks were supposed to occur twice daily at shift change over. However, we found these checks to be incomplete. It was noted that one controlled drug had not been checked on the first day of inspection. There were other four gaps in the twice daily checks between 24 December 2017 and 2 March 2018.

We found the drug cupboard in the resuscitation area to be very disordered on the first inspection day. Medicines were piled high and in no particular order. We observed a member of staff as they looked for a particular medicine. The cupboard was chaotic and disorganised with loose blister packs. The staff member found it difficult and time consuming to locate the medicine they were looking for. We were told of an incident one week before this inspection where staff could not locate medicine in the same cupboard required to treat a patient admitted in a collapsed state from Heathrow airport. It took some time for them to confirm that this drug was not available from the cupboard and had to be acquired from elsewhere. This cupboard was tidied and organised on the second inspection day.

An intravenous fluid warming unit was stored in a patient bay in the resuscitation area. On the day of inspection the unit was not locked. There was a digital lock on the warming unit but the code was written on the lock. We drew this to the attention of the chief pharmacist who told us this would be addressed.

There were inconsistent daily temperature recordings for the medicines refrigerator in the resuscitation area. There were 14 gaps in recording in January 2018; 11 in February and four gaps out of a potential seven to date in March 2018. We saw that maximum temperatures had been recorded above 8°C. In January 2018, there were maximum temperatures recorded of between 11.1 and 17.6°C on 13 days. In February, there were maximum temperatures recorded of between 8.2 and 19°C on 10 days. There was no record of action taken to ensure medicines were safe and effective to administer to patients.
Room thermometers had been installed where medicines were stored but staff were not recording the temperatures. Staff said that recording of room temperatures would commence in March 2018.

We noted that the care kit (Hypo box) that provided a range of glucose products for use in cases of low blood sugar in resuscitation was not checked daily; there were 16 gaps in recording in February 2018 and three gaps out of a potential seven to date in March 2018.

Medicines in the ED majors area were stored in a locked clinical room accessed via a key pad with keys held by the nursing staff. All cupboards were locked and were tidy and organised. Random samples of medicines from all cupboards were all in date. We saw that staff recorded temperatures daily for the medicines refrigerator in majors. All temperatures recorded for January, February and March 2018 were in the recommended range of 2 to 8°C.

Controlled Drugs were stored correctly. However, stock checks were meant to be done twice daily at shift change over; some of these were incomplete. It was noted that there were five checks missing in February and one out of a possible 14 checks in March.

We reviewed ED governance minutes and it was noted in the November 2017 meeting that a controlled drug was given to the wrong patient and was under investigation by the Nursing and Midwifery Council. The governance noted that staff should be reminded that two agency nurses cannot check controlled drugs; one staff member must be permanent.

A patient group direction (PGD) signed by a doctor and agreed by a pharmacist, can act as a direction to a nurse to supply and/or administer prescription-only medicines (POMs) to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription. We were told that whilst there were PGDs in place for analgesia and anti-inflammatory medicines, these were not in use as there was no PGD lead to oversee and monitor their use.

**Incidents**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2016 to November 2017, the trust reported no incidents classified as never events for urgent and emergency care.

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from December 2016 to November 2017.

Of these, the most common types of incident reported were:

- Sub-optimal care of the deteriorating patient meeting SI criteria - 78% of total incidents
- Apparent/actual/suspected self-inflicted harm meeting SI criteria - 11% of total incidents
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) - 11% of total incidents
Between February 2017 and January 2018 the emergency department reported 564 incidents. Of the these 404 (72%) were reported as no harm, 149 (26%) low harm, four (0.7%) were reported as moderate harm and two as severe harm (0.4%) and five were reported as death (0.9%) within the reporting period. We noted two of the four incidents reported as moderate related to lack of availability of equipment. One of these was recorded in March 2017 stated that the lack of equipment was anticipated and previously reported in February 2017. The other incident was reported in January 2018 and recorded as ‘only two infusion pumps in resus- one faulty and labelled as such and the other had no cover- therefore unable to be used’. The record also noted that concerns were expressed by the intensive care consultant as well as the on call ED consultant.

There were equipment supply issues recorded in November 2017 in an incident where a patient in cardiac arrest died. Equipment missing at the time included a temperature probe and end tidal CO2 lines for either the defibrillator or the temperature monitor and the laryngoscope had a paediatric rather than an adult handle on it. There was no suggestion that these missing pieces of equipment contributed to the patient’s death.

During inspection, we were told that there were some 500 incidents recorded on the electronic recording system which had not been reviewed. This was also recorded in the January minutes of the ED governance meeting which noted, ‘staff have had very limited time recently to go through the [electronically recorded incidents].’ There was no immediate solution proposed to this other than the hope was that nurses would have more time with a proposed plan for more allocated management time and doctors would have more time once the new consultants are in place [in March 2018].

The majority of staff told us they were encouraged to report incidents and the incident reporting culture was good within the hospital. Staff were able to identify how to report incidents and the types of situations that should trigger incident-reporting completion, including near miss situations. They told us lessons learnt were shared in team meetings and as part of the matron’s ‘Big 4’ handover noticeboard. This was a board which was regularly updated by the matron on which they placed key topics, recent incidents and learning and discussed at handovers. For example, staff were reminded to record patient allergies where there were recent incidents of penicillin allergic patients given penicillin. In another, staff were reminded to ensure they had correct discharge address to ensure the patient was transported to the correct address.
We observed a member of staff recording an incident electronically. This was an easy to follow process and was not time consuming for the staff member. A paediatric nurse described to us the most recent incident they recorded which related to a 19 year old patient placed on a paediatric ward. They told us they received feedback at the monthly team meeting, where all incidents were reported. Another nurse was able to describe an example of how they reported an incident relating to an incorrectly applied plaster cast. The incident was investigated, and actions were identified resulting in a review of procedures and an awareness campaign.

Student nurses told us they felt confident in their use of the electronic incident reporting system which they did with the support of full-time staff.

The trust had a major incident plan recently updated in February 2018. It was available on the intranet, as well as in hard copy available in the ED department. It covered eventualities taking into account the proximity of the hospital to a commercial airport, an RAF airport and private airfield; major motorways; tube line; university campus and large shopping centres.

Major incident awareness training was delivered as part of induction training. 95% of staff were trained as at September 2017. The trust had an emergency planning officer who maintained a working relationship with other stakeholders including the fire brigade; ambulance service; police and Heathrow airport. There were plans in place to respond to major incidents, including any occurrences at nearby Heathrow airport. These plans included delegation of authority and if necessary, site evacuation. We were told that there were annual exercises which included a live exercise and a table top in order to rehearse a variety of eventualities.

**Safety thermometer**

A full safety thermometer was not completed as this is a ward requirement rather than a requirement of an emergency department. However ED used a safety checklist and operational situation report to enable timely identification and management of risk, though we found that the safety checklist was seldom implemented.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new catheter urinary tract infections from December 2016 to December 2017 within urgent and emergency care.

**Is the service effective?**

**Evidence-based care and treatment**

We looked at various clinical policies and guidelines during the inspection within the emergency department (ED) and on the trust internet. We saw policies were based on NICE and best practice guidelines.

We were told the department took part in two Royal College of Emergency Medicine audits in 2016/17. These were RCEM Audit: Severe sepsis and septic shock 2016/17 and RCEM Audit: Moderate and Acute Severe Asthma 2016/17. However, because of challenges experienced in meeting the 16 hour standard on the consultant rota; the clinical work was prioritised over audit
work. The divisional leadership team told us they recently recruited consultants and once in post an audit lead would be nominated.

Staff showed us how they would access the local guidelines on the trust intranet. Junior doctors told us that clinical guidelines were easily accessible and were regularly updated. We saw examples of care pathways completed for patients who had presented with specific conditions such as head injuries and falls. These pathways followed evidence based guidance for management of treatment and conditions. Work around pathways meant that patients were accepted between specialties rather than being returned to ED for staff there to liaise with the different specialty.

The mental health matron had introduced a mental health file for staff in the adults and paediatric ED departments and all wards across the hospital. This included information about the Mental Health Act 1983, the Mental Capacity Act 2005, providing specialist support to patients in mental health crisis, and the service level agreement with the psychiatric liaison team. Staff carried out concurrent ED and mental health assessments, so that patients did not have to wait to be medically cleared before receiving mental health support.

**Nutrition and hydration**

In the CQC Emergency Department Survey, the trust scored 6.1 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as than other trusts. One parent in paediatric ED told us the vending machines in the department did not supply any snacks of particular nutritional value and the café was situated a long distance from the PED.

We were not assured that patients were regularly offered food and drink. Members of staff were unsure when the drinks trolley visited the department and we were told a volunteer from Friends of the Elderly gave drinks to patients in the afternoon.

On one occasion, we had to ask a nurse to take food and drink to a patient who was not on ‘nil by mouth’ and told us they felt cold and hungry. They were given tea and a sandwich as well as a blanket some thirty minutes later.

In the CQC Emergency Department Survey, the trust scored 5.4 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.

The trust scored 7.0 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
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</thead>
<tbody>
<tr>
<td>Q31. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>5.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q35. Were you able to get suitable food or drinks when you were in the emergency department?</td>
<td>6.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
There was a 'you said we did' board in the ED department in response to patient feedback in the Friends and Family test. We were told that as a result of a comment made by a patient who waited a long time for pain relief a safety checklist was introduced, whereby each patient’s pain levels should be reviewed on an hourly basis. However, we noted that these hourly checks did not take place on a regular basis. We also found that pain assessments were not done; there was no record of pain assessment made on six out of ten paediatric records and four out of thirteen adult records we reviewed.

Patient outcomes

In the 2016/17 Moderate and Acute Severe Asthma report, the trust failed to meet any of the standards.

The trust was in the upper UK quartile for one standard:

- **Standard 3 (fundamental):** High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. Trust: 54.4%; UK: 25%.

The trust was in the lower UK quartile for four standards:

- **Standard 2a (fundamental):** As per RCEM standards, vital signs should be measured and recorded on arrival at the ED. Trust: 6.3%; UK: 26%.
- **Standard 4 (fundamental):** Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. Trust: 60%; UK: 77%.
- **Standard 5:** If not already given before arrival to the ED, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
    - Standard 5b (fundamental): within 4 hours (moderate). Trust: 9.8%; UK: 28%.
- **Standard 9 (fundamental):** Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days
    - Trust: 29.8%; UK: 52%.
    - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
      - Standard 5a (fundamental): within 60 minutes of arrival (acute severe).
      - Trust: 7.1%; UK: 19%.

The trust’s results for the remaining two metrics were all between the upper and lower UK quartiles.

- **Standard 1a (fundamental):** O2 should be given on arrival to maintain sats 94-98%. Trust: 16.5%; UK: 19%.
- **Standard 5:** If not already given before arrival to the ED, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV

In the 2016/17 Consultant sign-off audit, the trust failed to meet any of the standards.

The trust was in the lowest UK quartile for two standards:
• Standard 1 (developmental): Consultant reviewed - atraumatic chest pain in patients aged 30 years and over 100%. Trust: 0%; England: 10.6%.
• Standard 3 (fundamental): Consultant reviewed – patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. Trust: 0%; UK: 12.2%.

The trust’s result for one standard was between the upper and lower UK quartiles:

• Standard 4 (developmental): Consultant reviewed – abdominal pain in patients aged 70 years and over. Trust: 14.3%; UK: 9.7%.

There were no results for the remaining standard:

• Standard 2 (developmental): Consultant reviewed – fever in children under 1 year of age.

The trust told us all patients with non-traumatic chest pain were expected to be discussed with a consultant prior to discharge. However, there was no audit data for consultant sign-off for this. We were also told by the trust that since there was 24/7 paediatric consultant presence in PED it was expected that all febrile children under 12 months would be discussed with or seen by a middle grade or consultant. However, there was no any audit data for consultant sign-off for this.

In the 2016/17 severe sepsis and septic shock audit, the trust failed to meet any of the eight standards (which were all 100%).

However, the trust was in the upper UK quartile for three standards:

• Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED. Trust: 98%; UK: 64.6%
• Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. Trust: 60%; UK: 43.2%
• Standard 7: Antibiotics administered: Within one hour of arrival. Trust: 60%; UK: 44.4%

The trust was in the lower UK quartile for two standards:

• Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. Trust: 6%; UK: 69.1%
• Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. Trust: 2%; UK: 18.4%

The trust’s results for the remaining three metrics were all between the upper and lower UK quartiles.

• Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. Trust: 12.8%; UK: 30.4%.
• Standard 4: Serum lactate measured within one hour of arrival. Trust: 40%; UK: 60%.
• Standard 5: Blood cultures obtained within one hour of arrival. Trust: 60%; UK: 44.9%.

Data submitted by the trust showed that between April and December 2017, between 97% and 100% of patients were screened. Of those, between 51% and 74% were administered antibiotics within an hour of arrival to ED.
In the 2015/16 Vital signs in children audit, the trust met the target for one of the six standards (which were all 100%).

The trust was in the upper England quartile for two developmental standards:

- **Standard 3 (developmental).** There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present). Trust: 88.2%; England: 69.7%.
- **Standard 5 (developmental).** Children with any recorded persistently abnormal vital signs who are subsequently discharged home should have documented evidence of review by a senior doctor (ST4 or above in emergency medicine or paediatrics, or equivalent non-training grade doctor). Trust: 100%; England: 60%.

The trust’s results for the remaining four metrics were all between the upper and lower England quartiles:

- **Standard 1.** All children attending the ED with a medical illness should have a set of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This should consist of:
  - **Standard 1a (fundamental) -** Temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score.
    - The trust score was 31.2% which was below the England score of 37.6%.
  - **Standard 1b (developmental).** Capillary refill time.
    - The trust score was 8.4% compared with the England score of 22.5%.
- **Standard 2 (developmental).** Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set. The trust score was 3.9% which was below the England score of 4.4%.
- **Standard 4 (fundamental).** There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases. The trust score was 84.3% which was above the England score of 73.2%.

In the 2015/16 Procedural sedation in adults audit, the trust failed to meet any of the audit standards (which were all 100%).

The trust was in the lower England quartile for all nine fundamental standards and all three developmental standards:

- **Standard 1 (fundamental):** Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including:
  - **Standard 1a. ASA grading**
  - **Standard 1b. Prediction of difficulty in airway management**
  - **Standard 1c. Pre-procedural fasting status**
    - Trust: 0%; England: 7.6%.
- **Standard 2 (developmental):** There should be documented evidence of the patient’s informed consent unless lack of mental capacity has been recorded. Trust: 9.9%; England: 51.8%.
- **Standard 3 (fundamental):** Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities. Trust: 53.1%; England: 90%.
- **Standard 4 (fundamental):** Procedural sedation requires the presence of all of the below:
  - **Standard 4a. A doctor as sedationist**
  - **Standard 4b. A second doctor, ENP or ANP as procedurist**
  - **Standard 4c. A nurse**
    - Trust: 4.9%; England: 40.8%.
- **Standard 5 (fundamental):** Monitoring during procedural sedation must be documented to have included all of the below:
- Standard 5a. Non-invasive blood pressure
- Standard 5b. Pulse oximetry
- Standard 5c. Capnography
- Standard 5d. ECG
  Trust: 1.2%; England: 23.9%.
- Standard 6 (developmental): Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area. Trust: 3.7%; England: 41%.
- Standard 7 (fundamental): Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:
  - Standard 7a (fundamental): Return to baseline level of consciousness.
  - Standard 7b (fundamental): Vital signs within normal limits for the patient.
  - Standard 7c (fundamental): Absence of respiratory compromise.
  - Standard 7d (fundamental): Absence of significant pain and discomfort.
  - Standard 7e (developmental): Written advice on discharge for all patients.
  Trust: 0%; England: 2.6%.

(Source: Royal College of Emergency Medicine)

In the 2015/16 Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast audit the trust failed to meet any of the audit standards (which were all 100%).

The trust was between the upper and lower England quartile for one of the two standards:

- Standard 2 (developmental): Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation. Trust: 15.7%; England: 2%.

The trust’s result for the remaining metric was not applicable.

The trust took part in an audit of the assessment and management of pre-operative pain in patients with a fractured neck of femur 2016. There was a fast track pathway for patients admitted via ED to enable a planned care package to be initiated promptly; ensure basic quality standards were met and initiate multidisciplinary team involvement. The aim of the audit was to improve the assessment and management of pre-operative pain in patients with neck of femur fractures and to assess whether current pain management adhered to NICE guidelines June 2011 [CG124]. This sets out that the patient's pain should be assessed immediately upon presentation to ED; reassessed within 30 minutes of administering the initial analgesia and hourly thereafter until settled on the ward. Results showed that of 20 patient notes reviewed, 13 patients (65%) had their pain assessed on admission; three (15%) had their pain reassessed within 30 minutes of analgesia and 15 (75%) were offered analgesia immediately. The identified area of good practice included the prescribing of additional analgesics for pain control (90%). The identified areas for improvement included better documentation of assessment of pain on arrival; to ensure patients were given analgesia immediately and regular reassessment of pain.

Between December 2016 and November 2017, the trust’s unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and generally about the same as the England average. In latest period, November 2017, trust performance was 8.7% compared to an England average of 7.6%.
Competent staff
We were told that there was teaching on one day per month for junior doctors and half a day for middle grades. However, some doctors told us that it was not always possible to get released to attend due to pressures of work in the department. In addition, there was little opportunity for on the floor teaching from consultants.

Simulation training uses a simulated task or environment to improve technical and non-technical skills. The focus is on patient safety and optimising team performance. We were told that simulation training happened occasionally but those whom we spoke with could not remember when this was last run.

Practice development nurses (PDNs) worked with nursing staff to ensure they were up to date with national guidance and any changes in guidance. PDNs also worked with all newly qualified nurses on a preceptorship programme. They referred to national guidance such as The National Institute for Health and Care Excellence (NICE) guidance and the Department of Health Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals.

Nursing staff told us they believed they had good education opportunities. The practice development nurse told us of the range of education they programmed which included a nurse trauma day (with simulated exercises); monthly nurse away days which they hoped to get accredited by the Royal College of Nursing; major incident training including chemical, biological, radiological and nuclear alerts and major incidents which generated major casualties including rail and aeroplane crashes. Other training included in-house paediatric and adult resuscitation training and mental health. Revalidation information was held by band 7 nurses and we were told there was support as required in order to complete revalidation.

There was a band 5 nurse development programme in place. Newly qualified nurses had a two year preceptorship programme which was signed off by the Royal College of Nursing and the Nursing and Midwifery Council. Preceptorship is a period of practical experience and training for a student of nursing, which is supervised by an expert or a specialist in a particular field. The band 5
nurses chose their preceptor (supervisor) and were supernumerary to the rota for their first two weeks in post.

There was a plan to provide additional training for band 2 and 3 staff (health care assistants) in venepuncture (intravenous injections and blood samples) and cannulation techniques.

The mental health matron and the psychiatric liaison team from the neighbouring mental health trust, provided training for ED staff in mental health awareness, addictions, and delirium. However, due to pressures over the winter, there had been fewer training sessions recently. Approximately 12 staff undertook training in mental health awareness in February 2018. A mental health day was planned, but had been postponed due to staff sickness.

Health care assistants received a three day induction, which included information about drug and alcohol awareness, and how to support patients with learning disabilities or autism. The mental health matron had developed a training package to train health care assistants on how to provide one to one support to patients in mental health crisis; this had not yet been launched. Four staff in paediatric ED were booked to attend a conference on working with adolescents with mental health issues.

Guidelines and protocols were easily accessible online and staff were able to demonstrate to us how they accessed them.

From December 2016 to November 2017, a total of 83% of staff within urgent and emergency care at the trust had received an appraisal, which was below the trust standard of 90%. Nursing staff appraisal rates were 98% which was above the trust standard. However, Medical & Dental staff had the lowest completion rate of 13%.

A split by staff group can be seen in the graph below:

<table>
<thead>
<tr>
<th>AC - Urgent and emergency services</th>
<th>No. required (YTD)</th>
<th>No. Staff who have received an appraisal (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to ambulance service staff</td>
<td>6</td>
<td>6</td>
<td>100%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>93</td>
<td>91</td>
<td>98%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>60</td>
<td>56</td>
<td>93%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>5</td>
<td>4</td>
<td>80%</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>31</td>
<td>4</td>
<td>13%</td>
</tr>
</tbody>
</table>

**Multidisciplinary working**

Board rounds are a summary discussion of the patient journey and what is required that day for it to progress. Any waits or delays for the patient are identified which enhances their experience and should minimise the risk factors associated with a prolonged stay in the emergency department (ED). They are often used as a teaching opportunity for the gathered staff.

We were told that board rounds should be held every two hours and involve all medical staff and a nurse in charge from each clinical area. We found that in general, the board rounds did not take place on a regular basis since the department was so busy. We observed one which was poorly
attended particularly by medical staff and was held close to an occupied cubicle which compromised patient confidentiality.

We observed positive teamwork between nursing and medical staff in the clinical decision unit. The interactions between administrative staff and ambulance crew were friendly and task-focused.

Staff were mixed in their views about general multidisciplinary working within the department. One doctor told us there was a general sense of lack of cohesion amongst the medical staff, with doctors frequently working in isolation and an absence of routine review or discussion of patients. We were also told that not all members of the consultant body were supportive and approachable.

Staff in the paediatric ED told us they worked closely with the paediatric department and attended multidisciplinary paediatric meetings on a monthly basis.

There was effective multidisciplinary working between the frailty team and the ED team. This meant there was appropriate assessment of frail elderly patients and where necessary, onward referral to the rapid assessment and discharge team.

Staff reported good links with the psychiatric liaison team provided by the neighbouring mental health trust. This was enhanced by the secondment of a mental health matron since December 2017. The matron told us they were working with the lead for children and adolescents mental health services, to promote better communication with ED.

Hillingdon hospital ED had a drug and alcohol specialist, and a dementia specialist. In addition the psychiatric liaison team also provided the support of a drug and alcohol specialist, and an older adults specialist. However, there was no learning disability lead for the trust and no departmental champion for ED and staff were unclear about the specialists to contact for support with patients with learning disabilities.

ED staff had regular meetings with the psychiatric liaison team, security staff, ambulance and a police liaison officer, who supported the security staff. These meetings involved looking at ways to divert frequent attender patients to other services where possible. Members of the psychiatric liaison staff often attended staff handover meetings in the hospital, and the mental health matron occasionally attended meetings at the psychiatric liaison team.

**Seven-day services**

The National Seven Day Services programme seeks to ensure that emergency and acute care is of that same high standard whichever day of the week a patient is admitted to hospital. Hillingdon Hospital is a first wave delivery site for the seven day services priority standards as part of a collaborative of trusts within North West London.

The recently introduced consultant rota meant that there was consultant cover in the ED majors from 8am until midnight seven days a week. We were told there were occasions when a speciality doctor or an ST6 trainee covered the shift, with a consultant (usually the deputy divisional director) on call from home. Middle grade cover was 24/7 and the paediatric ED had 24/7 consultant cover.
Diagnostic imaging was available on site 24/7; this included plain Film x-ray and computerised tomography (CT). Pathology service was also available 24/7. Ultra sound was available 9:00am to 5:00pm seven days a week. Magnetic resonance imaging (MRI) was available 9:00 to 4:30 Monday to Friday.

Clinical pharmacists provided a service Mondays to Fridays and a dispensary service was open on Saturday and Sunday mornings with 24/7 access to the on-call pharmacist. Frailty services were 9:00am to 5:00pm Monday to Friday with a Care Of the Elderly consultant embedded into the ED from 13:00 to 17:00 Monday to Friday.

Staff told us there was access to the on call mental health liaison service out of hours seven days a week. We were also told there was radiography available and there was an x-ray suite beside ED majors for sole use of the department.

Health promotion
There was a range of information leaflets available for patients in the ED department including information on healthy eating, smoking cessation, and managing diabetes. The paediatric emergency department had information for parents and carers around common childhood illnesses and conditions including wheeze management and chickenpox. There was also information displayed in the waiting room regarding bumps to the head and what signs to look out for. Patients had access to a drugs and alcohol liaison service which staff could refer them to.

The Hillingdon was part of a national Healthy Eating improvement initiative (CQUIN) 2018/2019 to reduce the amount of unhealthy food available to staff and patients. This included a commitment to provide 75% of food and 80% of confectionary as low calorie 80% of drinks as low sugar.

Staff told us there were various health initiatives across the hospital for staff. They gave examples of lunchtime walks for staff and pedometer challenges for staff. In January 2017, the trust took part in a ‘Healthy January’ campaign that set out to improve the health and wellbeing of staff by making available a range of activities staff could be involved in. Activities included signing up to a half marathon, taking part in ‘smoke free January’ or the over 40s NHS Health check by occupational therapy. Staff recommendations and lessons learnt from the campaign were used to plan future campaigns.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
Trust data showed there was 83% compliance with MCA and DoLS training for emergency care staff where the trust standard was 80%.

The trust submitted data between March 2017 and February 2018 for the use of handcuffs by on site security. This showed that handcuffs were applied on 10 occasions. On inspection, we observed one occasion where a patient was restrained by four security guards and subsequently handcuffed. This patient was not detained under a mental health section, there was no risk assessment, and the reasons for the decision to handcuff the patient were unclear.

We spoke with members of the site security team and ascertained that the trust ‘management of violence and aggression policy 2018’ refers to the management of a non-physical assault. However, there was no reference to the use of handcuffs in this or other trust policies related to
site security. A subsequent discussion with the trust chief executive officer and director of the Patient Experience and Nursing confirmed that the use of handcuffs was not written into any trust policy. The trust undertook to remedy this and subsequently submitted a policy ‘Adult and Young People Restraint Policy March 2018’. This included the use of handcuffs as a mechanical restraint option.

The psychiatric liaison team booked training sessions related to the Mental Health Act and Mental Capacity Act for staff at Hillingdon hospital. There was a plan to train two deprivation of liberty safeguards (DoLS) champions for each ward in the hospital.

The trust agreed a service level agreement with the mental health trust to undertake all Mental Health Act administration and ensure that detained patients had their Section 132 rights read from November 2017.

Is the service caring?

Compassionate care
The trust’s urgent and emergency care Friends and Family Test response rate between February 2017 and February 2018 varied between 0% 15.5% where the trust standard was 15% or greater. There were no results recorded for April 2017 and January 2018 and the average response rate was 6% of which between 89% and 96% recommended the department.

A&E Friends and Family Test Performance - The Hillingdon Hospitals NHS Foundation Trust

We found that patient experiences of paediatric ED and main ED differed. One parent told us, “The children’s area is lovely and clean. The medical staff are very friendly and professional; this is very different from the adult section.” Another said, “I have been treated with respect and I’m happy with the staff attitude. I’m pleasantly surprised.” Patients whom we spoke with in the clinical decision unit also spoke positively about staff. We were told “The staff here are brilliant; nothing is
trouble for them, they will do anything for you” and “Staff are very hard working, this area is very clean and the food is very good.”

We observed instances in the main ED where staff interactions with patients were not always done in a respectful and considerate way. For example, a patient made several attempts to find out which area they should go to for treatment. When asked, a doctor told them to find a nurse to speak with after which they returned to their computer screen. This same patient then located a nurse who acknowledged their presence after some time and suggested they go back to where they originally came from and did not give them any further guidance.

We saw where an elderly relative was instructed to relinquish their chair to give to a patient, despite other chairs being available in other parts of the majors area.

We also observed clashes of opinion between doctors and nurses played out in front of patients. Some patients commented on this and told us it was unpleasant to witness.

Staff did not always communicate with people so that they understand their care and treatment. Patients we spoke with in the pitstop queue were not always able to tell us what they were queueing for; in one instance, a patient did not realise that they were waiting for a bay within the ED majors area. Other patients told us they had asked for and not been given pain relief. One said “it is obvious that staff are really busy and I know they have forgotten about my pain killers but it’s not deliberate.”

We found the area in which walk-in patients were initially screened to be lacking in dignity and privacy. Patient history was taken through an open window close to where other patients were waiting to be seen. They leaned into the opening to have their temperature, heart rate and oxygen saturation taken.

We also saw how a mother struggled to remove their learning and physically disabled nine year old child from their adapted buggy and lift them onto the ledge to be seen by the streaming nurse. This child was significantly heavy and the mother’s difficulty to keep them sitting on the ledge was apparent.

We witnessed a maintenance person enter a patient’s cubicle in the EFAM area without seeking permission. They then proceeded to drill holes in the wall and fit a display frame. At no point was this person challenged or asked to delay their task. We asked a nurse to intervene by which time the patient shrugged and said the task could be finished.

The portable screens used for the fifth bay in the resuscitation area did not provide adequate screening. This additional bay was part corridor part storage area and compromised the patient’s privacy and dignity. Patients who were seen in the ED minors area had little privacy afforded to them since the area was very cramped and in most cases, the space between patients was less than one metre.

**Emotional support**
A patient told us they were “happy with the treatment, we experienced a friendly and professional service; staff understood how upset we were at having to come from the airport.” We observed a
member of staff in a resuscitation bay explain to a family member in a clear but supportive way what the likely prognosis was for their relative.

Several parents mentioned that nurses and doctors were reassuring in the paediatric ED, and that they felt calmer and more relaxed after speaking to clinical staff. A parent in paediatric ED told us “the staff are fantastic - so kind and understanding”.

**Understanding and involvement of patients and those close to them**

We found a significant difference in feedback from patients who experienced treatment in either the paediatric emergency department (PED) or ED majors. One mother in PED told us they were well informed about the condition and treatment of their child, “I feel confident about my child’s recovery.” However, one parent told us “the doctors could be better at sharing information with each other; that way, I wouldn’t have to keep repeating the same information.”

Some patients in the adult ED told us they had been treated with respect, informed about medications and any further treatment. Others said, “I don’t have any information about treatment and what will happen next because the staff are very busy; there is not enough information about timescales.” One patient who had been in the department for 16 hours, including an overnight stay told us, “the communication was very poor last night; the blood test results were delayed. It’s not clear what medications I need or when they will be prescribed. I don’t know when I’ll be allowed to eat.”

Many patients told us how difficult it was to find out information on how long they had to wait in the waiting area. One patient who was told they had to go to EFAM said, “Half hour ago I asked the receptionist how long I have to wait and she said “just wait”. I’m in pain and no one cares”.

We observed the early first assessment and management (EFAM) area where patients were assessed. During the course of one assessment with a nurse, there were five interruptions made by other members of staff. There were patient identifiable details disclosed on three of these occasions. On another occasion when a patient was having an ECG, two consultants discussed another patient’s details in this man’s cubicle.

The results of the CQC Emergency Department Survey 2016 showed that the trust scored worse than other trusts in 18 of the 24 questions relevant to caring. The trust scored about the same as other trusts for the remaining six questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>2.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>7.7</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.4</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.2</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.0</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>8.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>6.8</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>6.8</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.0</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>7.9</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>5.1</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>7.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.2</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>4.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>3.9</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>3.9</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>6.2</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q45. Overall</td>
<td>7.2</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey – September 2016)

**Is the service responsive?**

**Service delivery to meet the needs of local people**
The departmental business plan referenced the fact that the department was designed for up to 160 attendances per day, but was currently seeing up to 220 per day. This meant there was significant crowding in the department at times and resulted in a significant decrease in the four hour target. The business plan acknowledged that there was no designated ambulance transfer space, and the accommodation for mental health patients waiting for assessment or transfer to relevant treatment units was isolated and hard to monitor. We were told on inspection that work to expand the ED area would begin in April 2018 and be ready to receive patients by the end of August 2018.

The urgent care centre was run by an independent health care provider and was designed to see patients with an urgent condition or minor injuries. It provided care twenty four hours a day seven days a week. When patients entered the department they went first to a window where a receptionist took their presenting details and passed them onto a nurse who did a brief assessment and streamed them to different areas which included the urgent care centre or to the trust early first assessment and management (EFAM) which was an enhanced nurse and consultant lead triage system based in two triage rooms. Patients were usually directed from EFAM to go to the emergency department majors or minors or on occasions, to the urgent care centre to see the GP.

The waiting area was a small space with seats for approximately 50 patients and was used by all patients irrespective of which area they had been triaged to. This caused confusion as many patients we spoke with were unclear about where they were assigned to and how long it would be before they were seen. One member of staff told us they thought the way in which the waiting area was arranged was chaotic and confusing for patients.

The trust had access to a translation service. We were not assured that this was accessed where appropriate for all patients. For example, one elderly patient we observed was accompanied by his son, neither of whom spoke English as their first language. They were not offered the support of a translator at any time during the initial assessment. The son was asked to translate despite the fact that they did not speak English fluently and it is not considered good practice to use family members as translators.

There was no dedicated play worker in the paediatric ED. The post (0.5 whole time equivalent) became vacant 12 months ago and the plan was to combine this with a 0.5 healthcare assistant post; the job was going out to advertisement within weeks of this inspection.

The ED department had a system whereby comfort rounding of patients was meant to be carried out at regular intervals. Comfort rounds are a means whereby nursing staff pro-actively check on patients at timely intervals. These checks included pain levels and nutritional needs. However, there was no record of comfort round checks on any of the patient records reviewed despite these patients being in the department in excess of nine hours, six of whom were in excess of 15 hours.

The trust had a service level agreement with the psychiatric liaison team from a neighbouring mental health trust. The mental health matron was seconded from this trust, and had strong links with the psychiatric liaison team based a short distance away. They provided psychiatric nursing and consultant cover at all times. In addition, there was an alcohol liaison worker and a drug and alcohol specialist available for support in the department. The psychiatric liaison team also provided support from a drug and alcohol specialist, and an older adults specialist.
Meeting people’s individual needs
The clinical decision unit (CDU) was opened in January 2017 and was led and supervised by a consultant. It was used for short periods of observation, investigation or treatment prior to discharge. Patients who were sent to the CDU were required to be ambulatory. There were seven beds available 24/7 and five chairs available between 8:00am and 6:00pm.

There was a frailty service which was part of the home safe team but which assessed patients within the ED majors area. The service was introduced a year ago, and had a lead consultant and 2 nurses with a 10 bedded ward (Lister). They worked closely with the Home Safe Team. The aim of the service was to improve flow in the ED and ensure that frail patients were managed appropriately. Patients were assessed for which pathway best met their needs; these included discharge back to the community; admission to Lister ward (maximum 72 hour stay, eight beds and two trolleys); or admission to a ward if length of stay was likely to be greater than 72 hours.

An Elderly Care Consultant reviewed patients in ED and there were options to discharge and bring patients back for further assessment at clinic for example to the falls clinic. The team worked to prevent admissions and to prevent readmissions by working with community services and agencies. The frailty team got support as required from dementia nurse specialists and we were told that the mental health liaison team were also very supportive.

Patients over 65 were identified and they were assessed using a frailty score to measure severity of frailty as part of a comprehensive geriatric assessment. This score was recommended by the British Geriatric Society silver book.

Staff had begun to use a new format for assessing patients’ mental health needs in ED which facilitated mental health triage and risk assessment. This was introduced as a pilot one week prior to this inspection and included an assessment of the patient’s presenting complaint, medical and psychiatric history and diagnosis, any history of drug and alcohol use, risks to the patient or others, and any dependent children.

The information from the assessment led to a risk management plan, including the level of observations required and by what level of clinician.

However, where the new formats were not employed, it was difficult to find clear information on the paper records of patients’ mental health diagnosis, needs, and levels of observations.

As a result of some patients in crisis leaving the unit before a full assessment was undertaken, staff had begun to record the appearance and clothing of these patients. Staff gave examples of how situations could escalate quickly. For example, in a recent case when a patient at high risk of harm to themselves recently left the department without warning, they were supported to return to the unit with assistance from security staff.

There was no programme in place to address the matter of frequent attenders and there was no lead person with responsibility for this group of patients.

The trust recently developed practice guidelines for staff who worked with people with learning disabilities. This included guidance on means of communication and utilisation of a hospital
passport. There were two dementia boxes in the ED department; we found that most staff had a mixed understanding of both their availability and use. When asked if there were any resources to support care for patients with a learning difficulty, staff told us there was a folder, however this could not be located at the time of inspection so we were unable to see what the contents were.

We reviewed ED governance meetings and noted there was a reference to a complaint from a hearing impaired patient. It was documented that they had communication needs and the complainant said these were not met and no attempt was made to provide sign language.

The hospital’s proximity to Heathrow airport meant that patients taken ill during a flight or within the airport were conveyed to Hillingdon hospital by ambulance. There were 923 patients conveyed to the hospital from the airport between September 2017 and January 2018.

In the emergency department survey 2016 some patients complained to us about the length of time it took for them to get their prescription; some were waiting for over three hours. The trust scored “worse than” other trusts for all of the three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>6.4</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.0</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.5</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey – September 2016)

Access and flow
The streaming policy used by the independent healthcare provider was not shared with the trust. ED staff told us it would help them to understand more about the screening process if they could access it. CQC subsequently requested the streaming policy and were sent this by the healthcare provider.

The pathway between the streaming of walk-in patients at the front of the hospital (which was run by an independent care provider) and the emergency department (ED) did not always work in the patient’s best interest. We were told that there were times when it was difficult to get patients accepted into the ED due to high patient numbers. At such times, the patient was added to the GP list in the urgent care centre (UCC) and flagged as likely to need further intervention from ED.

For example, we saw a three year old paediatric patient with detergent sprayed into their eyes who was sent to the UCC nurse rather than to the eye treatment room in ED; we were told that the eye treatment room had an overnight patient in it and instead this young patient was instructed to hold their eye under a running tap which they found very challenging.

Another patient referred to the UCC was a 16 year old who felt faint and had a racing heart and history of anaemia. We observed them waiting to see the UCC GP in the general waiting area.
One parent we spoke with in the paediatric ED whose child had been detained overnight told us they found the initial booking in at reception the evening before very difficult. The waiting room was very busy and overcrowded. They were booked in at 7:30pm, waited approximately two hours for assessment at EFAM and were sent to the paediatric ED at 10:30pm.

Patients who were streamed to UCC and then back to EFAM had repeat observations done whilst in the UCC. However, there was no oversight maintained of those patients who were referred directly into the EFAM queue. We observed patients waiting for up to three hours to be seen with no repeat observations taken, despite the fact that these patients were identified as being in need of more urgent attention, hence why they were streamed to the EFAM.

We noted that several patients with a diagnosed mental illness spent over 15 hours in ED in the week prior to this inspection. Staff told us that the main reason for these delays related to accessing the appropriate type of service for the patient.

The trust followed the NHS operational pressures escalation levels (OPEL) framework the aim of which was to provide a consistent approach in times of pressure seven days a week. The policy described the escalation level criteria and risks which reflected the capacity of the ED and the process to be followed in the event of there being more patients than can be safely cared for.

The detail about which of the triggers contributed to the OPEL alert level was not captured in the trust data set, so it was not possible to say exactly which of the level three or four (the highest) alerts were due to overcrowding in the ED. We were told that it was likely to have contributed to the majority. There were 14 level three and four alerts between April 2017 and March 2018. Of these there were three level three and four level four alerts between January and March 2018.

There was an ambulatory care pathway which staff told us helped to reduce unnecessary admissions and readmissions. This was part of a recently built acute medical unit which included a consultant led ambulatory care unit. Patients deemed not sick enough to be admitted and not well enough to be discharged home straight away would be referred to the ambulatory care unit.

There was a new role of flow coordinator within ED majors. This was a fulltime post and it was the responsibility of the flow coordinator to book beds for patients ready to move from ED and ensure there was open communication between ED and the wards. They chased up blood results and were expected to maintain patient flow so that breaches were avoided. They told us their role was supported by the matron with whom they communicated up to five times per day. If required, the matron would assist with negotiations with specialisms to move patients onto wards.

We were told that the psychiatric liaison team was meeting the service level agreement of seeing all adult mental health patients within one hour of referral from ED. Staff indicated that the waiting time for the paediatric mental health liaison team was usually within three hours. Mental Health Act assessments could take longer due to delays in obtaining an approved mental health practitioner to assess the patient.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet the standard over the 12 month period from December 2016 to November 2017.
Over the 12 month period performance against this standard showed a trend of improvement. However, in the latest period, November 2017 the median time to treatment was 78.0 minutes compared to the England average of 60.0 minutes. The average time to treatment between February 2017 and February 2018 was 98 minutes.

Ambulance – Time to treatment from December 2016 to November 2017 at The Hillingdon Hospitals NHS Foundation Trust

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 ED. The department did not meet the target to admit, discharge, or transfer 95% of patients within four hours between February 2017 and February 2018. The percentage of patients discharged within the time standard varied between 40% and 60%. During one of our inspection days, there were 145 four hour breaches recorded with 467 attendances which meant that just 69% of patients were admitted, transferred or discharged within four hours on that day.

Four hour target performance - The Hillingdon Hospitals NHS Foundation Trust

(Source: NHS England - A&E Waiting times)

From January 2017 to December 2017, The Hillingdon Hospitals NHS Foundation Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being
admitted was similar to the England average. Performance against this metric showed a trend of improvement up to May 2017 and then declined, being worse than the England average in July 2017 and from October to December 2017.

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - The Hillingdon Hospitals NHS Foundation Trust**

![Graph showing percentage of patients waiting between four and 12 hours from the decision to admit until being admitted.](image)

*(Source: NHS England - A&E Waiting times)*.

Over the 12 months from January 2017 and December 2017, no patients waited more than 12 hours from the decision to admit until being admitted.

However, the trust adapted a system whereby they did not time the decision to admit until the responsible consultant confirmed the decision to admit, rather than from the time the patient was in the department. This was indicated on the electronic board as ‘awaiting bed – confirmed DTA’. We saw several instances where patients were in the department for between 12 and 27 hours and yet were not considered as being in breach of the 12 hour standard.

<table>
<thead>
<tr>
<th></th>
<th>Number of patients between 4 and 12 hours</th>
<th>Number of patients over 12 hours</th>
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<td>0</td>
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<tr>
<td>Feb-17</td>
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<td>May-17</td>
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<td>Jun-17</td>
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<tr>
<td>Jul-17</td>
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<tr>
<td>Aug-17</td>
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<tr>
<td>Jan-18</td>
<td>652</td>
<td>0</td>
</tr>
<tr>
<td>Feb-18</td>
<td>284</td>
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</table>
From December 2016 to November 2017 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment ranged from 1.8% to 3.1% and was generally better than the England average.

From December 2016 to November 2017 performance against this metric showed a trend of improvement. In the latest period, November 2017, the median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was 2.3%, compared to the England average which was 2.5%.

From December 2016 to November 2017 the trust’s monthly median total time in A&E for all patients was consistently higher than the England average. Performance against this metric showed a slight trend of improvement. In the latest period, November 2017, the trust’s monthly median total time in A&E for all patients was 193, which is worse than that of the England average of 152.

Median total time in A&E per patient - The Hillingdon Hospitals NHS Foundation Trust
Learning from complaints and concerns

From November 2016 to November 2017 there were 72 complaints about urgent and emergency care services. The most prevalent department/area was ‘assess, check and treat’ with 55 complaints (75% of total). The trust took an average of 37 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed in 30 days. Most patients we spoke with were aware of how to make a complaint and said they would consider raising their concerns with the patient advice liaison service (PALS).

There were nine open complaints on the ED complaint register at the time of this inspection five of which related to patient care. Lessons learnt included better clarity with patients about their projected journey from the emergency department to other specialties within the trust. This was reinforced at the ‘big 4’ handover board. Other learning identified included a review of results and audit time pathway to inform GP of abnormal results; this complaint was closed shortly before this inspection so the pathway was not yet reviewed. Staff told us they ensured patients were discharged with their own medication. They said this followed a complaint from a patient discharged with another’s medication and the learning was reiterated at handover for a period of time.

There were leaflets on public display about how to make a complaint, as well as information on PALS. There was a more simplified easy read leaflet available in for patients who struggled to use the standard complaints form.

Is the service well-led?

Leadership

The emergency department sat within the division of medicine. It was led by a divisional director and a divisional director of nursing and a divisional director of operations. In addition there was a deputy divisional director who was a consultant and an emergency services manager. The emergency department had a clinical lead and two matrons, one for general ED and one for paediatric ED.

The operational team were visible and engaged and many staff could tell us who they were. The trust management team told us their focus was on improvement in ED both of service delivery and patient experience.

We saw examples of clinical leadership from some members the consultant body, but more junior doctors told us that leadership was dependent on the consultant in question and how approachable they were.

We observed nursing shift coordinators to be capable and efficient, multi- tasking while allocating tasks to the nursing team in order to maximise their impact on patient care. Most nursing staff reported that their matron was visible and supportive and had made mostly positive changes to the running of the department.
Vision and strategy
The trust had plans to create two self-contained ensuite rooms in which suspected infectious patients brought from Heathrow airport would be assessed. Building works were due to start which included the extension of the ED area to create a rapid assessment area. The vision was to have an emergency floor which was flowed well with few physical barriers. The development of the CDU had a positive impact on patient flow, however, it was acknowledged that there were times when patients were held in the CDU for longer than the expected maximum 24 hours whilst awaiting a bed on a hospital ward.

The trust values were communication; attitude; responsibility; equity and safety (CARES) were visible throughout the department. Staff we spoke with were aware of what the values stood for. Work was to begin in April 2018 on the expansion of the ED area. It was acknowledged that recruitment of staff must go alongside this physical expansion.

Culture
Some staff spoke to us about how they relied on their colleagues and good teamwork to work in what were often challenging circumstances. They told us that the trust leadership was target driven with pressure channelled downwards to staff at a local level. We were told that staff felt stressed but there was little opportunity to escalate concerns as they did not feel it would have any impact on alleviating their day to day challenges.

We found there was no access control across the department apart from paediatric ED. This had the potential to expose patients to risk as we observed members of the public moving freely between most areas of the ED unchallenged, including through resuscitation and the ambulance bay.

Staff told us the trust was a good employer and some whom we spoke with said they had felt supported at times when they experienced health problems. Many said they were proud to work for the trust and believed they made a difference to better patient care. Staff we spoke with were aware of the trust whistleblowing policy and were aware of the trust ‘freedom to speak up’ guardian. Most said they would feel confident to raise concerns if needed.

Governance
The emergency department sat within the division of medicine. Executive level accountability for ED performance was the responsibility of the chief operating officer. The medical director was responsible for patient safety and the director of patient experience and nursing was responsible for quality.

There was a non-executive director for medicine and emergency care. The trust quality committee was a sub-committee of the board and received quality report updates from the division of medicine (including emergency care) on a quarterly basis.

The ED clinical governance group was established in 2015 and met each month. The agenda rotated each month with a focus on either morbidity or mortality (M&M), audit or trauma as the main agenda item. Serious incidents, Duty of Candour and complaints were discussed at every
meeting. The expectation was that band 7 nurses took responsibility to disseminate information from these meetings to their teams.

We reviewed minutes of ED clinical governance meetings and saw that actions were identified and responsibility assigned to individuals. However, there was no recorded progress report or update on the status of these actions in subsequent minutes we read. Governance and performance information was shared with staff in a monthly newsletter available via the trust intranet.

Members of the emergency department leadership team attended weekly meetings with the independent healthcare provider responsible for streaming patients and running the urgent care centre. This was a business meeting which reviewed what worked well or could be improved on from the previous week. The trust did not have oversight of this provider’s streaming policy or streaming performance data. CQC requested this separately from the healthcare provider. This was submitted with the proviso that it was not to be shared with the trust since it was commercially sensitive information.

**Management of risk, issues and performance**

There was no plan in place to mitigate the risk of the large numbers of unreviewed incidents on the electronic incident register.

Regular meetings were held with the independent healthcare provider responsible for streaming patients and running the urgent care centre. Minutes showed that discussions included the possibility of sharing major incident training on decontamination in order to respond to increased acid attacks and the agreement of a chest pain pathway between the UCC and ED.

The ED clinical governance team met on a monthly basis. Membership of this team included the clinical lead and governance lead; clinical Lead for M&M; clinical lead for audit and clinical lead for trauma. The agenda rotated each month and focused on one of these lead areas as the main agenda item. Ongoing complaints, serious incidents and Duty of Candour were discussed at every meeting.

Members of the divisional leadership team told us their top three risks related to space and capacity; access; mental health patients. There were nine risks on the register, of which one was rated high; five moderate and three low.

These risks were not all the same as those identified by staff. Several staff told us they had concerns about the risk at “the front door” in relation to assessment and streaming which was not on the risk register. They said there was a feeling of chaos in the general waiting area. They also said there was no evidence based assessment tool and quality of streaming was variable and the waiting times for EFAM were frequently lengthy but not monitored by the trust which placed patients at risk.

Other risks identified by staff included lack of controlled access by people who were not necessarily patients of the department and lack of equipment. We noted that the use of a fifth bay in the resuscitation area was not on the risk register, despite it being employed almost on a daily basis and without a specific written protocol for consistency of use.
Emergency department risks which were also on the corporate risk register included lack of capacity; care of psychiatric patients in ED and risks of violence to patients and staff in ED. Other risks included the availability of pressure relieving products at the point of need to minimise the risk of pressure ulcers. The number and experience of paediatric staff (medical and nursing) in the ED department was also on the corporate risk register.

There was no separately held risk register for the paediatric ED department. Amongst the risks included on the ED risk register was capacity which was rated 16 and was placed on the risk register in April 2017. Concerns identified related to the lack of capacity included quality of patient care could be compromised; overwhelming pressure placed on staff and cancellation of operations. We noted that one of the controls introduced was listed as ‘managing the corridor care is now in place’. However, we did not observe any of this corridor management during inspection.

Another risk was the care of psychiatric patients in ED which had first been placed on the risk register in June 2011. It was noted that the room where mental health patients were taken to was isolated with easy access to rest of the hospital. This was rated moderate and six on the register. Further risks included incidences of violence to patients and staff in ED (moderate rated six). Staff reported improvements since the introduction of a mental health matron within the A&E team.

The treatment of septic patients in ED which was rated moderate six and was first placed on the risk register in October 2014. Details on the risk register noted that Royal College of Emergency Medicine Standards for severe sepsis and septic shock were not always met. Lack of a dedicated paediatric nurse allocated to triage 24/7 was rated moderate six and had been first placed on the risk register in August 2015.

Potential refusal or delays to the referral of patients with traumatic spinal fractures and other spinal injuries to another hospital was listed as low three. We noted that the lack of fit for purpose ultrasound machine in ED was on the risk register since October 2013. A new machine was purchased in 2014 however, the risk register stated that ED doctors were not receiving training in ultrasound therefore the trust was not meeting College of Emergency Medicine requirements for all trainee doctors to receive training in ultrasound. This risk was last updated in October 2017.

The potential lack of experienced medical and nursing paediatric staff in ED was rated as three low. This was on the register since November 2013 and most recently reviewed in October 2017 when it was noted that all staffing gaps had been filled.

We reviewed minutes from ED risk management meetings held on a monthly basis and which had a set agenda. Different items were discussed each month on rotation; for example mortality and morbidity (M&M) incidents; serious incidents and complaints. We saw that where serious incidents occurred, lessons learnt were identified. Recent lessons learnt included a mix up with a prescription where the dosage was miscommunicated. It was agreed that staff should always use the actual strength required when prescribing.

The November agenda of the risk management meeting included a morbidity and mortality report where recent deaths were discussed. One death identified had been declared a serious incident. Reasons identified included the patient was put on air rather than oxygen supply which was changed once noted. During the investigation the lack of adequate equipment was identified; there was no manual resuscitator available. This is a hand-held device used to provide positive pressure
ventilation to patients who are not breathing or not breathing adequately. It was also noted that there was only one CT scanner available for the whole hospital and a shortage of thermometers. We were told there had been a large turnover of staff in the clinical governance team which presented challenges. Information from the clinical governance meeting is shared with band 7 nurses who then disseminate it to their teams.

Paediatric ED shared clinical governance meetings with general paediatrics and maintained a separate paediatric ED risk register. There were five open risks, three of which were rated as moderate and two low. A moderate risks included the lack of trollies in the paediatric department. Another was the delay in availability of clinical notes and correspondence when a patient was admitted from the paediatric emergency department to the ward. The third risk rated as moderate was the lack of staff to perform triage.

The trust followed the NHS operational pressures escalation levels (OPEL) framework the aim of which was to provide a consistent approach in times of pressure seven days a week. The policy described the escalation level criteria and risks which reflected the capacity of the ED and the process to be followed in the event of there being more patients than can be safely cared for. The detail about which of the triggers contributed to the OPEL alert level was not captured in the trust data set, so it was not possible to say exactly which of the level three or four (the highest) alerts were due to overcrowding in the ED. We were told that it was likely to have contributed to the majority. There were 14 level three and four alerts between April 2017 and March 2018. Of these there were three level three and four level four alerts between January and March 2018.

Information management

Administrative staff told us the trust’s electronic systems were easy to use, and the training received to use them was good. The electronic system indicated if there was a child protection plan in place and if there are any domestic violence concerns.

Engagement

Patient feedback was received through Friends and Family Test; Internal surveys; national patient surveys and NHS Choices. Feedback was also monitored through complaints, concerns raised by Patient Advice and Liaison Service (PALS); Healthwatch; Hillingdon 4 All and direct contact with governors or members of the board.

Thirty eight percent of staff in the emergency care service responded to the 2017 staff survey, compared with an overall response rate of 53% for the rest of the hospital. Staff comments about their job included 63% looked forward to going to work compared with the trust response rate of 65%. Eighty percent said they could show initiative in their job compared with 74% for the rest of the trust. Eighty one percent of staff said they had to communicate closely with each other to achieve the team's objectives compared with 77% of the rest of the trust.

However, some significant variations between responses from the emergency care service and the rest of the trust included 31% felt they had adequate materials, supplies and equipment to do their work compared with 49% of the rest of the trust; 20% felt there were enough staff to do their job properly compared with 32% for others. Other results included 49% felt team members had a set of shared objectives compared with trust score of 69% and 40% felt team members often met to discuss the team's effectiveness compared with 58% of the rest of the trust.
Seventy five percent had not experienced harassment, bullying or abuse from managers compared with 86% of the rest of the trust and 63% had not experienced physical violence from patients, their relatives or other members of the public compared with 87% of the rest of the trust. Seventy six percent of staff recorded they had training, learning or development in the last 12 months compared with 67% of the rest of the trust. Ninety percent recorded they had training which helped them to do their job more effectively compared with a trust response of 85%. Thirty percent of staff felt the organisation took positive action on health and well-being compared with 34% of the rest of the trust and 59% of staff would recommend the trust as place to work compared with 61% of the rest of the trust.

There were leaflets around the department encouraging patients and relatives to participate in the friends and family test (FFT). The paediatric ED had child friendly tests which included colourful faces and simple language.

The trust encouraged staff to record incidences of great effort, support and positive interactions with colleagues.

**Learning, continuous improvement and innovation**

Members of the senior leadership team told us they considered the introduction of the early first assessment and management (EFAM) system to contribute towards the continuous improvement of the department. They also said the ‘Pitstop’ area within ED majors meant an improved experience for patients. They told us they had placed a significant emphasis on staff recruitment since the last CQC inspection which had begun to make a noticeable impact on patient experience.

We were also told that the introduction of the ‘big 4’ in the safety huddle emphasised the importance of reflecting on local challenges and highlighting improvements in those areas. The trust had introduced a number of improvements for patients with mental health issues, including better risk assessment and recording systems, and a pool of registered mental health to be used flexibly throughout the hospital.

The emergency care business plan for 2018-2019 identified priorities to improve quality and clinical standards. These included a focus on the sepsis pathway; FFT response for quality measurement; infection control process; safety checklist (NHSI) and the four hour standard. The strategic priorities for 2018-2021 included improvement on the 4 hour standard and a reduction in ambulance handover times. It stated that the redevelopment of the ED and the operational procedures for addressing those standards were key to achieving improvements. It was noted that an increased establishment of consultants will enable them to become more strategic in their approach. The development of pathways from ED to specialty assessment units was also identified as key to improvements.

The trust was being supported by the NHS Improvement Emergency Care Improvement Programme Team (ECIP); the main focus of which was improvement at the front of the hospital. A member of the ECIP team told us a new concordat was recently agreed between the trust, local clinical commissioning group, ambulance provider and ECIP. The concordat set out the next set of priorities which should be adapted in order to continue to improve patient outcomes and achieve greater efficiency.
The department held a patient appropriate care and treatment week (PACT) prior to this inspection. This was designed to unblock the system and allow for an improved patient journey and more efficient use of resources. During this week, all hospital services attended two briefings each day which provided a forum for individuals to suggest how they could contribute to patient discharges. We were told that on one of the PACT days, 14 patients were discharged before 10am, which relieved the pressure of space in the ED department. We were told that the trust board was considering whether this approach was sustainable.

Other priorities for the department with support from ECIP included consideration of how ambulance handovers could be more efficient and improved flow and hotspots which affect this. The trust and local ambulance provider committed to the NHS Improvement Red2Green project. This recognises that patient time is most important in healthcare. Red days are defined as those days that fail to contribute to a patient’s discharge from hospital. Green days are where a patient receives an intervention that supports their care pathway out of hospital and into the best setting for their needs.

There was an away morning for all consultants on one inspection day; members of the divisional leadership team told us the focus of this was about getting the team working together again and working out ways forward which would improve patient flow and experience; as well as better utilisation of resources.
Medical care (including older people’s care)

Facts and data about this service

The division of medicine at the trust delivers a standard suite of medical and older people’s inpatient services at the Hillingdon Hospital site including acute medicine, ambulatory care, respiratory, gastroenterology, neurology and stroke, care of the elderly, cardiology, Endocrinology, rheumatology, and haematology.

The trust does not have a renal service; however, an acute medical consultant with renal training provides support to the medical teams caring for patients with renal impairment.

In addition to these services, the trust provides a specialist level two neuro-rehabilitation unit with 20 beds (Alderbourne ward). This service accepts tertiary transfer patients and repatriations from major trauma units.

The endoscopy department carries out both diagnostic and therapeutic treatment for patients as well as staffing a 24/7 bleed rota. Within the department three nurse specialists provide diagnostic endoscopy in addition to four consultants.

There are 254 medical inpatient beds located across 12 wards at The Hillingdon Hospital:

<table>
<thead>
<tr>
<th>Ward Name</th>
<th>Number of inpatient beds</th>
<th>Description of ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alderbourne</td>
<td>20</td>
<td>Rehabilitation Services for Adults - Level 2</td>
</tr>
<tr>
<td>Beaconsfield East</td>
<td>20</td>
<td>Care of the Elderly and Dementia Services</td>
</tr>
<tr>
<td>Bevan</td>
<td>24</td>
<td>Gastroenterology and Haematology</td>
</tr>
<tr>
<td>Churchill Ward</td>
<td>20</td>
<td>Endocrinology Services</td>
</tr>
<tr>
<td>Coronary Care Unit</td>
<td>7</td>
<td>Cardiac Services - seven adult beds and one room for image intensifying purposes</td>
</tr>
<tr>
<td>Drayton Ward</td>
<td>18</td>
<td>Respiratory Service including BIPAP and Opti flow</td>
</tr>
<tr>
<td>Fleming Cardiology and Escalation Ward</td>
<td>29</td>
<td>Cardiology and Escalation ward</td>
</tr>
<tr>
<td>Grange Ward</td>
<td>30</td>
<td>Care of the Elderly</td>
</tr>
<tr>
<td>Hayes Ward</td>
<td>30</td>
<td>Care of the Elderly</td>
</tr>
<tr>
<td>Lister Frailty Unit</td>
<td>10</td>
<td>Care of the Elderly/Frailty Services</td>
</tr>
<tr>
<td>Pinewood Ward</td>
<td>20</td>
<td>Escalation Ward</td>
</tr>
<tr>
<td>The Stroke Unit</td>
<td>26</td>
<td>Stroke Unit</td>
</tr>
</tbody>
</table>

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

The service also has a 29-bedded Acute Medical Unit (AMU).

The trust had 25,326 medical admissions from October 2016 to September 2017. Emergency admissions accounted for 10,992 (43%), 256 (1%) were elective, and the remaining 14,078 (56%) were day case.

Admissions for the top three medical specialties were:
• Gastroenterology; 7,516
• General Medicine; 5,180
• Pain Management; 3,083

(Source: CQC Insight)

During this inspection we visited all the above wards. We also visited the AMU, the ambulatory care unit and the endoscopy department. Between March 2017 and February 2018, ambulatory care saw 15,009 new patients and followed up 6,712.

During our inspection, we spoke with 52 members of staff including health care assistants, doctors, nurses, allied health professionals and ancillary staff. We also spoke with the divisional leadership team, 20 patients and 10 relatives. We reviewed 22 sets of patient records including prescription charts and various pieces of equipment.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training
The trust set targets between 80-95% for completion of mandatory training.

A breakdown of compliance for mandatory courses from April 2017 to November 2017 for all staff at Hillingdon Hospital in medical care (including older people’s care) is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained (YTD)</th>
<th>Number eligible (YTD)</th>
<th>Completion (%) YTD</th>
<th>Target Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>90%</td>
<td>29</td>
<td>30</td>
<td>97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>80%</td>
<td>413</td>
<td>433</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>80%</td>
<td>406</td>
<td>433</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Corporate Induction</td>
<td>80%</td>
<td>97</td>
<td>107</td>
<td>91%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>80%</td>
<td>392</td>
<td>433</td>
<td>91%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>80%</td>
<td>305</td>
<td>357</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>90%</td>
<td>306</td>
<td>373</td>
<td>82%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>353</td>
<td>433</td>
<td>82%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>80%</td>
<td>228</td>
<td>281</td>
<td>81%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>80%</td>
<td>254</td>
<td>320</td>
<td>79%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>80%</td>
<td>312</td>
<td>403</td>
<td>77%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 3 years</td>
<td>80%</td>
<td>47</td>
<td>71</td>
<td>66%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>80%</td>
<td>82</td>
<td>125</td>
<td>66%</td>
<td>No</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>3224</td>
<td>3799</td>
<td>85%</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)
Six out of 13 mandatory training modules failed to meet the target completion rate. Manual handling – object and fire safety (three years) both had the lowest completion rates of 66% compared to the trust target of 80%.

As of April 2018, the mandatory training completion rate was 88%. The table below shows the compliance rates broken down by staff grade.

| Medical and Dental staff - Hospital | 86.22% |
| NHS infrastructure support         | 90.48% |
| Other Qualified Scientific, Therapeutic & Technical staff | 100.00% |
| Public Health & Community Health Services | 93.94% |
| Qualified nursing & health visiting staff (Qualified nurses) | 88.03% |
| Support to doctors and nursing staff | 87.50% |
| Support to Scientific, Therapeutic & Technical staff | 90.32% |

(Source: Data request DR375)

The service had a policy on sepsis management and most staff were able to show us how to access the policy on the trust intranet.

Senior staff working in the care of the elderly services told us staff had an hour-long mandatory training session on dementia as part of their induction. They also told us that staff were sent for further training at a local university the trust is in partnership with.

**Safeguarding**
The trust set targets between 80-90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April 2017 to November 2017 for all staff at Hillingdon Hospital in medical care (including older people’s care) is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained (YTD)</th>
<th>Number eligible (YTD)</th>
<th>Completion (%) YTD</th>
<th>Target Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>90%</td>
<td>398</td>
<td>433</td>
<td>92%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>80%</td>
<td>397</td>
<td>433</td>
<td>92%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>90%</td>
<td>366</td>
<td>403</td>
<td>91%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td></td>
<td><strong>1161</strong></td>
<td><strong>1269</strong></td>
<td><strong>92%</strong></td>
<td></td>
</tr>
</tbody>
</table>

All three safeguarding modules met the trust target.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff showed an understanding of the trust’s safeguarding protocols and were knowledgeable about what might constitute a safeguarding concern.

The safeguarding leads for both adults and children’s safeguarding explained the trust’s safeguarding procedures in relation to female genital mutilation. The service had arrangements in place to safeguard women and children with, or at risk of, female genital mutilation (FGM).
On the wards, staff were knowledgeable about female genital mutilation and were positive above the FGM training delivered as part of their mandatory safeguarding training.

**Cleanliness, infection control and hygiene**

The environment on the medical wards was generally visibly clean and tidy. However, we noticed some high level dust on some wards such as Beaconsfield, Grange and, Pinewood.

Staff followed the trust's infection control policy, for example washing their hands in between attending to patients, using personal protective equipment such as gloves and aprons, and adhered to the trust’s ‘bare below the elbow’ policy.

During the inspection in 2015, we found that the service did not always carry out infection control audits such as hand hygiene and bare below the elbow audits. During the most recent inspection we found that the service had made improvements in relation to this. Senior staff carried out various infection control audits such as hand hygiene, bare below the elbow, and audits related to the use of intravenous devices and catheters.

Performance was variable across the medical wards. For example, in December 2017 there was 100% compliance with hand hygiene on Drayton, Bevan, and Grange wards with the lowest performance recorded being 75% on Alderbourne. Performance was higher in February 2018, with the lowest compliance recorded being 80% on Beaconsfield, and 85% on Alderbourne. There was 100% compliance on Fleming, Grange, Hayes and Bevan.

For the bare below the elbow audit for February 2018, the lowest scores were 83% on Hayes and 88% on Bevan. The other medical wards scored higher and compliance ranged between 90% and 100%.

Signed cleaning schedules were visible on most of the wards indicating when cleaning had been completed and when it was due.

Staff in radiology told us that patients with infectious diseases such as tuberculosis, who they were aware of, wore a mask when attending radiology and were seen as a priority in order to protect others from the risk of infection.

Infection prevention and control practices in the endoscopy unit and the decontamination unit were in line with national guidance and good practice. The decontamination unit used for endoscopy equipment demonstrated the ‘dirty to clean’ pathway. The ‘dirty to clean’ pathway minimises the risk of dirty instruments used in carrying out endoscopies contaminating clean equipment.

However, the trust did not have a named individual as the authorised person or competent person for endoscopes. This is an individual trained and qualified to ensure all endoscope machines are commissioned to HTM01-01: Decontamination of reusable medical devices (health test memorandum –HTM). At the time of our inspection, the post had been vacant for 11 months.

We found that antibacterial hand gel was readily available at entrance and exit points to the wards and other medical areas. We observed staff using hand gel on entering and exiting the wards.
Patient curtains had been changed in accordance with trust policy but on some wards we found curtains that had not been properly secured and were hanging loose. This was the case on Hayes and Grange wards.

**Environment and equipment**

Not all portable electrical appliances had been tested. When we asked senior staff about this they told us that new appliances would only be tested at the next cycle (April of each year). However, we still found old appliances that had not been tested. We made similar findings at the previous inspection.

On most of the wards, staff had correctly segregated clinical and non-clinical waste in line with HTM 07-01, Control of Substances Hazardous to Health (COSHH), and the Health and Safety at Work Regulations. However, on Pinewood we found that waste, including hazardous waste had been stored on the ward which was not in line with the regulations or with best practice. When we asked staff about this they told us that waste would be taken and disposed of at the end of each shift. This did not meet the above requirements.

In order to meet increasing demand, some bays in the Acute Medical Unit (AMU) had been divided to create two beds where there would normally be one bed. This meant that only one of the two beds had an oxygen port and a call bell. Senior staff told us a risk assessment was undertaken before patients were allocated to the beds without oxygen port or call bell system. We immediately raised this concern with the chief executive.

Across the medical wards, staff had labelled sharps bins and we did not see any sharps bins which were overfull.

There had been a refurbishment of the therapies gymnasium and first bed bay on the stroke unit which was an improvement from the last inspection.

**Assessing and responding to patient risk**

Staff assessed patients in key safety areas such as falls, skin integrity, venous thromboembolism (VTE), and nutrition on admission using national risk assessment tools. We checked nine patient records on five separate wards and found that VTE assessments, pressure ulcers, nutrition, falls had been completed in all nine records.

Staff used the National Early Warning Score (NEWS) competency-based escalation trigger protocol to assess and respond to patients at risk of deterioration. Staff escalated deteriorating patients by dialling 2222 which was the emergency number for the hospital. A response team attended the ward to attend to the deteriorating patient. The trust had recently introduced an electronic system for the recording of NEWS.

Staff told us that they made junior doctors aware of any urgent or unplanned admissions for them to arrange that these patients were within 12 hours of admission by a consultant or other relevant medical practitioner. Staff used ward and board rounds to identify patients requiring assessments by a consultant.
We checked nine patient records for evidence that patients transferred from the acute area of the hospital to a general ward had been reviewed during a consultant-delivered ward round at least once every 24 hours unless it had been determined that this would not affect the patient’s care pathway. We found that eight out of the nine patients had been seen in post take ward round within 12 hours of admission to a ward. Staff told us during the weekend patients were not always seen once every 24 hours due to the availability of consultants.

An audit on NEWS in October 2017 showed that staff had appropriately escalated NEWS scores but did not always clearly document this in the patients’ records. However, we checked nine patient records on five different wards for the recording, calculation and escalation of NEWS scores. We found that in all nine records NEWS had been recorded, calculated and escalated where appropriate and this had been documented in the patients’ records.

A critical care outreach team was located within the hospital and attended medical wards when requested.

There was evidence of the use of a sepsis care bundle for the management of patients with presumed or confirmed sepsis. Staff told us about the ‘sepsis 6’ care bundle which was used in the hospital. We also found that the screensavers on staff computers reminded staff about the sepsis six protocol and its key actions.

Junior doctors told us there was an additional prompt to consider sepsis when getting blood tests done for a patient.

Although staff knew how to identify and escalate a patient who may be at risk of sepsis, it was not clear what standard tool or document was used within the hospital to record when a diagnosis of sepsis had been made or to indicate that antibiotics had been given within one hour. Staff showed us different forms used to record each step that had been taken.

Following the inspection, we asked the hospital to send us the tool used by staff in the management of sepsis. The document provided matched what we had seen or had been shown by staff on some but not all the wards.

Sepsis audits showed good performance by inpatient wards in relation to sepsis screening. There was 100% compliance between October 2017 and February 2018. However, audits showed that compliance was lower in relation to patients requiring treatment being given antibiotics within one hour. The trust target was 90% and compliance was 92% (11 out of 12) in October 2017, 100% (6 out of 6) in November 2017, 87.5% (7 out of 8) in December 2017, 69% (9 out of 13) in January 2018 and 100% (5 out of 5) in February 2018.

A mental health matron was the main point of contact in relation to specialist mental health support for staff concerned about risks associated with a patient’s mental health. More widely, the trust had a service level agreement with another trust in relation to access to 24/7 mental health liaison services.

The service had on site access to a high dependency and critical care unit which could be used for patients requiring that level of care.
Nurse staffing
The service used an acuity tool to plan the numbers of staff needed on each ward in relation to the patient needs of each ward. However, due to staff shortages we found that the planned staff numbers did not always match with the actual staff numbers.

The Hillingdon Hospital reported their staffing numbers below for the period April 2017 to November 2017. Nursing staff reached 68% of planned capacity as at November 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Planned Staff</th>
<th>Number in post as at November 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Hillingdon Hospital</td>
<td>243.4</td>
<td>164.8</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From December 2016 to November 2017, Hillingdon Hospital reported a vacancy rate of 29% in medicine, compared to the trust target of 8%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

As at March 2018 medical services at Hillingdon Hospital reported a vacancy rate of 36% compared to the trust target of 8%.

(Source: Additional Information Request DR305)

At the time of our inspection, there were multiple junior staff nurse vacancies. For example, there were eight junior nurse vacancies on Grange, three on the Cardiology Care Unit (CCU), four on Churchill, five on Lister and five on Hayes. The leadership of the service were actively trying to recruit staff into these posts. The service had rolling advertisements for staff nurse vacancies and an open day once a month which was a recruitment opportunity. Senior staff had also taken part in the recruitment of nurses from abroad.

From December 2016 to November 2017, Hillingdon Hospital reported a turnover rate of 12% in medicine for qualified nursing staff, compared to the trust target of 13%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From December 2016 to November 2017, Hillingdon Hospital reported a sickness rate of 3% in medicine for qualified nursing, compared to the trust target of 3%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Medical care had 19,013 shifts filled by bank and agency staff which was the highest core service uptake within the trust tentatively suggesting that the trust are managing vacancies.

The trust did not provide accurate data for the total number of shifts overall and therefore we are unable to calculate the total number of shifts covered by bank and agency and the number of shifts left unfilled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)
Staff told us that senior staff used bank and agency staff to cover gaps in the nursing staff provision. However, staff also said that agency staff often did not arrive for their shifts which meant that staff often had to work with lower numbers of staff on duty.

Some patients told us staffing was a concern on the wards. They said this sometimes meant having to wait longer to get requests fulfilled. For example, patients said it took longer for call bells to be responded to at night due to lower numbers of staff at night.

**Medical staffing**

Three consultants covered the Acute Medical Unit (AMU) between 7am and 7pm Mondays to Fridays. After 7pm, an on-call registrar covered the AMU. There was also access to an on-call consultant overnight.

The medical staffing model on the acute medical unit had recently changed to consultant-led teams managing the acute take and ward beds separately, thus freeing up specialty consultants to manage their wards.

At the weekend a consultant covered AMU between 7am and 7pm but they also covered the rest of the hospital. There was on call consultant cover between 7pm and 7am at weekends.

The service had three cardiologists who covered the cardiology ward (Fleming) on separate days each week. Other patients on that ward who did not fall under cardiology were seen by an acute medical consultant.

Some medical wards had consultants based on the ward during the day, for example on Alderbourne (rehabilitation).

Junior doctor vacancies were highlighted as a risk on the service’s risk register. Staff reported they were often short of junior doctors at night which meant that patients were not always seen as soon as nursing staff made the request. Staff told us two junior doctors covered AMU at night and another two covered the rest of the hospital.

The Hillingdon Hospital have reported their staffing numbers below for the period April 2017 to November 2017. Medical staff reached 92% of planned capacity as at November 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Planned Staff</th>
<th>Number in post as at November 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Hillingdon Hospital</td>
<td>54.4</td>
<td>49.8</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From December 2016 to November 2017, Hillingdon Hospital reported a vacancy rate of 0% in medicine, compared to the trust target of 8%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
As at March 2018, medical services at the Hillingdon Hospital reported a vacancy rate of 10% compared to the trust target of 8%.

(Source: Additional Information Request DR305)

From December 2016 to November 2017, Hillingdon Hospital reported a turnover rate of 39% in medicine, compared to the trust target of 13%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

The leadership acknowledged that recruitment and retention were a concern in medical services and said they were continually working on recruiting staff, including from overseas and engaging more with staff in order to obtain their views and encourage retention.

From December 2016 to November 2017, Hillingdon Hospital reported a sickness rate of 0% in medicine for medical staff, compared to the trust target of 3%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The trust did not provide accurate data for the total number of shifts overall and therefore we were unable to calculate the total number of shifts covered by bank and locum and the number of shifts left unfilled.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

In September 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 98 whole time equivalent staff working in medicine at The Hillingdon Hospitals NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>48%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>18%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>28%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (SIR) 1-6
* Junior = Foundation Year 1-2

Source: NHS Digital - Workforce statistics (01/09/2017 - 30/09/2017)
Records
The trust used both electronic and paper records. We looked at 20 patient records including risk assessments, prescription charts and nursing and medical records. There had been an improvement in relation to the completion of patients’ records. We found that staff had legibly completed patients’ records and signed to indicate who had completed the record and what staff grade they were.

Details of mental health assessments by the mental health liaison team were available in the patient records.

Staff stored patient records in lockable cupboards and trolleys and were conscious about maintaining the privacy of patient information.

We found inconsistencies in relation to the completion of dementia assessments which we found were not always completed even where patients were over 75 years old. Although senior staff within the service told us that a dementia specialist nurse checked completion of dementia assessments these were not consistently completed across the medical wards.

On Pinewood we saw two patients whose bed rails were in situ but staff were unable to show us the bed rail assessments which had had been completed.

At our previous inspection we found that some agency staff did not have access to the electronic patient record system. During this inspection we still found that not all agency staff had access to the electronic patient records. We also found that not all agency staff could admit and discharge patients as they did not have access to the patient record system.

Medicines
During the announced part of the inspection we checked medicines management on Pinewood, Bevan Ward, Beaconsfield East and the female Day Care unit for medical, inpatient outliers. We found that the service had made improvements to the safe storage of medicines and intravenous fluids since the last inspection in 2014. Medicines stocked on the wards and departments were stored securely.

However, on one of the wards staff had not taken action in relation to fridge temperatures which were out of the optimal range. This meant that staff could not be assured that medicines were safe and effective to administer to patients.

Room thermometers had been installed in treatment rooms but staff were not recording the temperatures. Staff said that recording of room temperatures would commence in March 2018.

Oxygen cylinders were not checked regularly to make sure they were at least three-quarters full. On one ward, the two oxygen cylinders in stock were empty. This was not in line with good practice or the trust’s policy.

The ordering, storage and administration of controlled drugs was in accordance with the Misuse of Drugs Act 1971 and the associated regulations. Wards visited had suitable cupboards to store controlled drugs.
Although medicines had not been managed appropriately in relation to Pinewood, Bevan and Beaconsfield wards there had been managed appropriately on Drayton, Stroke and Churchill.

We checked resuscitation trolleys on endoscopy, Grange, Lister, Stroke, AMU and Pinewood and found that they had been appropriately stocked and replenished and that daily checks had been carried out and recorded.

We checked nine prescription charts for the completion of allergies information and this had been completed in all nine records.

Staff across medical wards were aware of trust policy and Nursing and Midwifery Council standards for the administration of controlled drugs.

At the previous inspection we found that staff did not prescribe oxygen for patients requiring it. This was still the case at this inspection. The trust’s policy stated that oxygen needed prescribing in all but emergency situations. Staff were therefore not prescribing oxygen in line with the trust’s own policy.

**Incidents**

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

From December 2016 to November 2017, the trust reported no incidents classified as never events for medicine.

*Source: NHS Improvement - STEIS (December 2016 - November 2017)*

In accordance with the Serious Incident Framework 2015, the trust reported 15 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from December 2016 to November 2017.

Of these, the most common types of incident reported were:

- Slips/trips falls meeting SI criteria with six (40% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with four (27% of total incidents).
- Treatment delay meeting SI criteria with two (13% of total incidents).
• Medication incident meeting SI criteria with two (13% of total incidents).
• Pressure ulcer meeting SI criteria with one (7% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Staff used an electronic computer incident reporting system which could be accessed on the hospitals computers. Staff were aware of how to report incidents and could show us how to access the reporting system on the trust intranet page.

There was an incident reporting culture within the service and this was evident in our interviews with staff of all levels. Staff also told us they were encouraged to report incidents. Staff were able to identify how to report incidents and the types of situations that should trigger incident-reporting completion, including near miss situations.

Ward managers and matrons gave staff feedback following incidents and there was evidence of learning from incidents. Learning was shared via a range of methods including emails, staff meetings and daily safety huddles.

We reviewed three of the serious incidents reported in medical services and found that senior staff had carried out investigations for all three. For each investigation there had been an analysis of what caused the incident, what lessons were learnt from the incidents, recommendations and a mention of how the service would monitor arrangements for sharing and learning from incidents. These incident investigations showed that duty of candour had been applied.

There were inconsistencies in relation to the major incident plan for the service. The trust policy stated that updated hard copies of the major incident plan were to be kept on every ward. However, during the inspection not all wards had updated major incident plans on the ward. For example, on AMU and Bevan the hard copies were dated 2008 even though the most recent updated copy was dated 2018. However, on both these wards staff could show us an updated version of the major incident plan on the trust intranet.

Safety Thermometer
The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 10 new pressure ulcers, 23 falls with harm and 21 new catheter urinary tract infections from December 2016 to December 2017 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at The Hillingdon Hospitals NHS Foundation Trust

...
Total Pressure ulcers (10)

Total Falls (23)

Total CUTIs (21)

Source: Safety thermometer - Safety Thermometer

Following our previous inspection in 2014 we reported that safety thermometer results were not displayed on some of the wards. The service had made an improvement in relation to this. All medical wards displayed safety thermometer results on their noticeboards.

Is the service effective?

Evidence-based care and treatment

Patient assessments used by staff were based on national tools such as the Nutrition Screening Tool (NST) and the National Early Warning Scores (NEWS). Care pathways based on national guidance were in place for conditions such as sepsis, stroke and pressure ulcers.

Staff referred to national guidance such as The National Institute for Health and Care Excellence (NICE) guidance and trust policies in carrying out their roles.

There was a system for monitoring the use of NICE guidelines within the trust and within the service. Clinical audit facilitators checked and reviewed the use of NICE guidance. The service also used NICE implementation support tools such as the baseline assessment tool.

A clinical audit and effectiveness committee met every two months to review national and local guidance and make changes to trust policy as necessary.

Patients in the Acute Medical Unit (AMU) were seen and reviewed by a consultant twice daily in line with best practice.

Endoscopic procedures, for example, diagnostic upper GI endoscopy were carried out in line with professional guidance. The service was engaged with Joint Advisory Group on GI Endoscopy (JAG) but had not yet been JAG accredited. JAG accreditation is a formal recognition that an
endoscopy service is fully competent to deliver against specific measures, as identified by the ‘Global Rating Scale (GRS)’ standards.

Patients transferred from the acute area of the hospital to a general ward were reviewed during a consultant-delivered ward round at least once every 24 hours unless it has been determined that this would not be necessary or would not affect the patient’s care pathway.

**Nutrition and hydration**
Staff screened patients for risk of malnutrition on admission. We checked nine patient records on five different wards and found that nutritional assessments had been consistently completed in all nine records.

Patients had access to dietitian and speech and language therapy (SALT) services. SALTs worked closely with nursing and medical staff in assessing and supporting patients with eating, drinking and swallowing needs. Staff were aware of the hospital’s protocol for referring patients to a dietitian or SALT.

Staff used the ‘red tray’ system to indicate patients requiring assistance during mealtimes. This meant that staff could easily identify which patients required assistance.

The service operated a protected mealtime policy to ensure that patients would not be disturbed during mealtimes.

Patient feedback on the food was variable with some saying it was good and others stating the food was “just ok”.

**Pain relief**
Assessments of patient’s pain were included in a routine set of observations. Patients were asked to rate the severity of their pain between one and 10. These pain scores were recorded in patient’s records. Staff used the Abbey pain score to assess pain for patients unable to verbalise.

Patients reported that they were able to access pain relief when they requested it. However, some patients said they sometimes had to wait before they could get their pain relief if there were fewer than normal staff on duty.

**Patient Outcomes**
From September 2016 to August 2017, patients at the trust had a lower than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions
- Patients in clinical haematology had a lower than expected risk of readmission for elective admissions
- Patients in pain management had a lower than expected risk of readmission for elective admissions
- Patients in general medicine had a similar to expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a higher than expected risk of readmission for non-elective admissions

Elective Admissions – Trust Level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

Non-Elective Admissions – Trust Level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

(Source: HES - Readmissions (September 2016 – August 2017))

From September 2016 to August 2017, patients at Hillingdon Hospital had a lower than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in clinical haematology had a lower than expected risk of readmission for elective admissions
- Patients in gastroenterology had a higher than expected risk of readmission for elective admissions
- Patients in dermatology had a lower than expected risk of readmission for elective admissions
- Patients in general medicine had a similar to expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a higher than expected risk of readmission for non-elective admissions

Elective Admissions - Hillingdon Hospital
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

Non-Elective Admissions - Hillingdon Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

The Hillingdon Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade B in latest audit, April to June 2017. This is an improvement on the previous quarter, January to March 2017 where Hillingdon Hospital achieved grade C.

Team-centred KI levels

<table>
<thead>
<tr>
<th></th>
<th>Jan-Mar 17</th>
<th>Apr-Jun 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Scanning</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2) Stroke unit¹</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>3) Thrombolysis</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>4) Specialist Assessments</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>5) Occupational therapy</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>6) Physiotherapy</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>7) Speech and Language therapy</td>
<td>B</td>
<td>A</td>
</tr>
<tr>
<td>8) MDT working</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>9) Standards by discharge</td>
<td>B</td>
<td>A</td>
</tr>
<tr>
<td>10) Discharge processes</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>

Team-centred SSNAP level (after adjustments): C - C
Team-centred Total KI level: A - A

Overall scores

<table>
<thead>
<tr>
<th></th>
<th>Jan-Mar 17</th>
<th>Apr-Jun 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>C</td>
<td>B</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>E</td>
<td>B</td>
</tr>
<tr>
<td>Combined Total Key Indicator level</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>

1 Included in IM reporting, indicator SSNAPD02
Results for The Hillingdon Hospitals NHS Foundation Trust in the 2016 Heart Failure Audit were better than the England and Wales average for all four of the standards relating to in-hospital care.

Results for The Hillingdon Hospitals NHS Foundation Trust results were better than the England and Wales average for five of the seven standards relating to discharge.
Referral to HF liaison service (54.1%) and referral to liaison service (LSVD only) (61.9%) were the two standards that were below the England and Wales average of 54.8% and 70.8% respectively.

*SOURCE: NICOR - Heart Failure Audit (April 2015 – March 2016)*

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2016 National Diabetes Inpatient Audit identified 104 inpatients with diabetes at the trust; 95.2% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this trust in quartile four.

Patients reporting that they could take control of their diabetes care was in quartile four in 2015 with 70.6% (compared to the England results of 59.4%) and remained in quartile four in 2016 with 81.4% (compared to the England results of 60%).

Patients reporting choice of suitable meals, and mild hypoglycaemic episodes (3.0-3.9mmol/L) have both moved from quartile four in 2015 to quartile three in 2016.

*(Source: NHS Digital)*

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2015 to March 2016, 40.7% of nSTEMI patients were admitted to a cardiac unit or ward at Hillingdon Hospital and 95.5% were seen by a cardiologist or member of the team compared to an England average of 55.8% and 96.2% respectively.
The proportion of nSTEMI patients who were referred for or had angiography at Hillingdon Hospital was 96.5% compared to an England average of 79%.

<table>
<thead>
<tr>
<th>2015/16</th>
<th>nSTEMI patients seen by a cardiologist or a member of team</th>
<th>nSTEMI patients admitted to cardiac unit or ward</th>
<th>nSTEMI patients that were referred for or had angiography (incl. after discharge)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hillingdon Hospital</td>
<td>312</td>
<td>312</td>
<td>198 (198)</td>
</tr>
<tr>
<td></td>
<td>95.5%</td>
<td>40.7%</td>
<td>96.5% (No data)</td>
</tr>
<tr>
<td>England: overall</td>
<td>47039</td>
<td>47039</td>
<td>39082 (39082)</td>
</tr>
<tr>
<td></td>
<td>96.2%</td>
<td>55.8%</td>
<td>83.6% (No data)</td>
</tr>
</tbody>
</table>

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 86%, which does not meet the audit minimum standard of 90%. The 2015 figure was 88%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 13.5%; this is not significantly different from the national level. The 2015 figure was 7%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 70%; this is not significantly different from the national level. The 2015 figure was 32%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 57.1%; this is not significantly different from the national level. The 2015 figure was 100%. We asked the service to comment on the lower figure of 57% compared to the 2015 figure of 100% but the service did not provide this information.

(Source: National Lung Cancer Audit)

The trust had a multi-disciplinary falls committee where data on falls was discussed. Minutes from this meeting were reported to the patient safety committee. The trust also had a falls lead.

The crude proportion of patients who had a vision assessment (if applicable) was 17.9%; this did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) 5.9%; this did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 20%; this did not meet the national aspirational standard of 100%.

The crude proportion of patients with appropriate mobility aid in reach (if applicable) was 46.2%; this did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)
Competent staff
Agency staff received local induction on the wards they worked on. This included being shown around the ward and senior staff checking their competencies to work on the ward. Senior staff used a competency checklist in order to check competencies for agency staff. However, not all wards were able to show us completed checklists for agency staff induction or competency checks which meant that we were not assured that all agency staff working within medical services had the competencies to be providing care to the patients they looked after.

On Drayton (respiratory ward) there was evidence of staff receiving training related to the nature of patients they cared for. We saw a competency folder with information on staff who had completed non-invasive ventilation training and training on the use of ventilation equipment. We also found that the critical care outreach team provided tracheotomy training for staff on this ward.

A respiratory support team saw all newly diagnosed respiratory patients on Drayton ward and educated staff on supporting these patients.

The service did not have practice educators or practice development nurses to aid in staff competencies and training. We found that this was on the services’ risk register and senior staff had made a business case for these posts to be created and recruited into.

Staff working with patients requiring non-invasive ventilation on AMU had received appropriate training relating to working with these patients.

Following the previous inspection in 2014, we reported that not all staff providing care to elderly patients had received the appropriate training. During this inspection, staff working on the elderly care told us they had received training relevant to looking after elderly patients. The trust provided training specific to caring for elderly patients. For example, staff had opportunities to attend hourly sessions on nutrition in the elderly, palliative care, frailty syndrome, movement disorders, osteoporosis and bone health, and falls and hip fractures.

Newly qualified staff had preceptorships and had opportunities to rotate between wards and specialities. Although the service did not have practice development nurses, newly qualified staff said their line managers supported them in relation to any competencies they felt they lacked or needed further training on.

A mental health matron had been recruited to the service six months prior to our inspection. Their role involved the training of staff on mental health related topics. Staff found the matron’s input to be invaluable.

Staff reported regular supervision by their managers and other seniors. Junior staff also told us of the trust’s plan for apprenticeships and said this was something they looked forward to.

While nursing staff completed medicine training and competency assessments on induction, the trust did not have an education programme to update medicine training. We spoke with nurses who had been working for the trust for more than five years and had not received updates to their medicine training since their induction. Nursing staff informed us that there was no process to
periodically assess their competencies relating to medicines. The trust later refuted this and said that a programme was in place.

There was no continence lead for the service or a continence nurse specialist for the service. This meant that the service could not be assured that staff were competent to using continence appliances such as catheters. The lack of a continence nurse specialist was a risk on the services register.

From April 2017 to November 2017, 95% of staff within the medicine division at Hillingdon Hospital had received an appraisal. The trust did not provide an appraisal target rate. Medical & Dental staff had the lowest completion rate of 48%.

A split by staff group can be seen in the graph below:

<table>
<thead>
<tr>
<th>AC - Medical care (including older people’s care)</th>
<th>No. staff required (YTD)</th>
<th>No. staff who have received an appraisal (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>7</td>
<td>7</td>
<td>100%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>32</td>
<td>32</td>
<td>100%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>184</td>
<td>181</td>
<td>98%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>164</td>
<td>159</td>
<td>97%</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>21</td>
<td>10</td>
<td>48%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Multidisciplinary working
Throughout our inspection, we saw evidence of multidisciplinary team (MDT) working in the ward areas. Relevant professionals were involved in the assessment, planning and delivery of patient care.

The care records that we examined confirmed active involvement from health professionals of different disciplines where appropriate. For example, patient records showed the involvement of occupational therapists, speech and language therapists, physiotherapists and dietitians as well as appropriate referrals to specialist nurses or teams.

Staff informed us that information relating to older people with complex needs was included in the patient discharge summary which was made available to the patients’ general practitioners and community teams responsible for their care following discharge.

The names of the professionals with overall responsibility for each patient’s care, for example, consultants, were displayed on the whiteboards on the wards and team members were aware of who had overall responsibility for each patient.
The service had links to community services in relation to its ‘Discharge 2 Assess’ initiative. The service worked with community services, social services and third sector to develop pathways to support patients in going home from hospital as soon as clinically appropriate.

**Seven-day services**
The ambulatory care unit provided a seven-day service between 730am and 8pm. This was a consultant led service.

The service had improved in relation to radiology cover out of hours. Radiology services were available from 8am to 7pm Mondays to Fridays. Outside these hours, an external provider provided on call radiology cover. At weekends, a radiologist was onsite between 10am and 1pm. Additionally, a radiologist was on call between 8am and 8pm.

Endoscopy provided a six-day service between 8am and 630pm Mondays to Fridays and between 8am and 4pm on Saturdays.

Clinical pharmacists provided a ward based service Mondays to Fridays and a dispensary service open on Saturday and Sunday mornings.

**Health promotion**
Medical wards had noticeboards with information about how patients could improve their health. There was information on healthy eating, smoking cessation, and managing diabetes.

Patients had access to a drugs and alcohol liaison service which staff could refer them to.

Staff told us there were various health initiatives across the hospital for staff. They gave examples of lunchtime walks for staff and pedometer challenges for staff.

In January 2017, the trust took part in a ‘Healthy January’ campaign that set out to improve the health and wellbeing of staff by making available a range of activities staff could be involved in. Activities included signing up to a half marathon, taking part in ‘smoke free January’ or the over 40s NHS Health check by occupational therapy. Staff recommendations and lessons learnt from the campaign were used to plan future campaigns.

**Consent, Mental Capacity Act and DoLS**
Mental Capacity Act training was part of the trust’s safeguarding training. Staff told us they had received this training. Most staff demonstrated a good knowledge of the principles of informed and implied consent as well as the Mental Capacity Act (2005).

We found inconsistencies in relation to the completion of capacity assessments for patients subject to Deprivation of Liberty Safeguards (DoLS). For example, on Fleming ward, only one out of three patients subject to a DoLS had a capacity assessment in their medical records. Although we saw some completed capacity assessments on some wards, completion and filing of capacity assessments was not done consistently on all the wards.
On our unannounced inspection, staff told us a patient on Alderbourne was subject to DoLS but there was no DoLS paperwork on the patient's file or evidence that it had been completed. Staff did not know why the patient was subject to DoLS. Following the inspection, the hospital informed us they had investigated this incident. The patient was indeed subject to a DoLS but staff had not printed out the electronic confirmation of the DoLS. The hospital told us this had since been placed on the patient’s records.

Following the inspection, we asked for information on how staff were kept informed of patients’ DoLS statuses and the hospital told us that DoLS were discussed in ward and department handovers, including reasons why a patient was subject to a DoLS and any relevant updates. They also said that information on DoLS is was included in the electronic patients recording system.

Two patients on Pinewood had bed rails in situ but staff had not completed bed rail assessments. We also found that staff did not always complete dementia assessments in accordance with the Trust policy.

Is the service caring?

Compassionate care
We spoke with 20 patients during this inspection. Most patients spoke positively about their experiences being cared for at the hospital with some patients describing staff as “excellent”, “very friendly”, and “so kind.”

We observed kind and compassionate interactions between staff and patients.

We found that staff respected patients’ privacy and dignity across medical wards. On Beaconsfield, we noticed that nursing staff had two pegs on their uniforms which they used to make the curtains around patients’ beds more secure when providing care to patients to stop them from opening accidentally.

On all medical wards, we observed thank you cards from patients, relatives and carers which had been displayed on the walls. There were many messages thanking staff for their kindness and compassion.

The Friends and Family Test response rate for medicine at Hillingdon Hospital was 27% which was similar to the England average of 25% from December 2016 to November 2017.

Friends and family Test – Response rate from December 2016 to November 2017 by site
Friends and family Test – Response rate from December 2016 to November 2017 by ward

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Avg. Response Rate Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Annual performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMU</td>
<td>1032</td>
<td>21%</td>
<td>95%</td>
<td>89%</td>
<td>92%</td>
<td>84%</td>
<td>96%</td>
<td>94%</td>
<td>95%</td>
<td>98%</td>
<td>93%</td>
<td>95%</td>
<td>92%</td>
<td>86%</td>
</tr>
<tr>
<td>Stroke Unit</td>
<td>319</td>
<td>106%</td>
<td>87%</td>
<td>79%</td>
<td>100%</td>
<td>91%</td>
<td>100%</td>
<td>79%</td>
<td>93%</td>
<td>97%</td>
<td>86%</td>
<td>87%</td>
<td>96%</td>
<td>75%</td>
</tr>
<tr>
<td>Grange</td>
<td>202</td>
<td>44%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>96%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>94%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Beaconsfield east</td>
<td>200</td>
<td>92%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>92%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<td>100%</td>
<td>100%</td>
<td>88%</td>
<td>88%</td>
</tr>
<tr>
<td>Lister</td>
<td>155</td>
<td>31%</td>
<td>88%</td>
<td>100%</td>
<td>86%</td>
<td>100%</td>
<td>92%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>96%</td>
<td>100%</td>
<td>88%</td>
<td>95%</td>
</tr>
<tr>
<td>Pinewood</td>
<td>152</td>
<td>24%</td>
<td>100%</td>
<td>89%</td>
<td>95%</td>
<td>85%</td>
<td>100%</td>
<td>93%</td>
<td>100%</td>
<td>96%</td>
<td>87%</td>
<td>89%</td>
<td>93%</td>
<td>93%</td>
</tr>
<tr>
<td>Churchill</td>
<td>129</td>
<td>25%</td>
<td>100%</td>
<td>83%</td>
<td>83%</td>
<td>91%</td>
<td>92%</td>
<td>67%</td>
<td>75%</td>
<td>87%</td>
<td>90%</td>
<td>85%</td>
<td>94%</td>
<td>94%</td>
</tr>
<tr>
<td>Drayton</td>
<td>123</td>
<td>19%</td>
<td>94%</td>
<td>95%</td>
<td>75%</td>
<td>100%</td>
<td>90%</td>
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<td>86%</td>
<td>100%</td>
<td>96%</td>
<td>96%</td>
<td>100%</td>
<td>97%</td>
</tr>
<tr>
<td>Bevan</td>
<td>114</td>
<td>14%</td>
<td>100%</td>
<td>52%</td>
<td>100%</td>
<td>100%</td>
<td>92%</td>
<td>91%</td>
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<td>96%</td>
<td>100%</td>
<td>100%</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>CCU</td>
<td>110</td>
<td>46%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Hayes</td>
<td>95</td>
<td>17%</td>
<td>100%</td>
<td>100%</td>
<td>88%</td>
<td>94%</td>
<td>86%</td>
<td>92%</td>
<td>93%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Alderbourne</td>
<td>47</td>
<td>32%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Daniels</td>
<td>42</td>
<td>47%</td>
<td>86%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>97%</td>
</tr>
</tbody>
</table>

(Source: NHS England Friends and Family Test)

**Emotional support**

Most of the wards had a room which staff could use to break bad news or have confidential conversations with relatives or carers. We found that even where there was no dedicated room staff improvised and used other rooms whilst still maintaining privacy and dignity.

Patients told us staff provided emotional support during their stay at the hospital. One patient told us how they had been comforted by staff after they had become upset. Another patient said when they felt upset or angry staff made an effort to connect with them and find out if anything was wrong.

Understanding and involvement of patients and those close to them

Not all patients we spoke with said they felt involved in their care. One patient on Hayes said staff did not explain their treatment plan to them. Another patient said that staff did not have a discussion with them about the use of bed rails and simply put them up. However, most patients said they felt involved in their care and that staff kept them updated.

**Is the service responsive?**
Service planning and delivery to meet the needs of the local people

The service experienced high demand to its services because of a high volume of patients coming to the hospital via the accident and emergency department (A&E). In response to this high demand, the service had opened escalation areas within the hospital in order to increase capacity. Pinewood ward was opened as an escalation ward in 2016 but had remained open indefinitely in order to address capacity. The discharge lounge had also been turned into an escalation area.

The service’s ambulatory care pathway reduced unnecessary admissions and readmissions. The newly built Acute Medical Unit (AMU) included a consultant led ambulatory care unit. Patients seen in ambulatory care came to the hospital via general practitioner (GP) referrals, in hospital transfers, and transfers from A&E. Between March 2017 and February 2018 ambulatory care saw 15,009 new patients and followed up 6,712 patients.

The service worked with community partners to come up with initiatives where patients would not stay in hospital for longer that clinically required. A ten-bedded frailty unit had been established on Lister ward. Frailty nurses assessed patients and discharged eligible patients home early on supported discharge pathways.

From October 2016 to September 2017 the average length of stay for medical elective patients at the trust was 10.4 days, which is higher than the England average of 4.2 days. For medical non-elective patients, the average length of stay was 7.8 days, which is higher than the England average of 6.6 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in clinical haematology is higher than the England average.
- Average length of stay for elective patients in gastroenterology is higher than the England average.
- Average length of stay for elective patients in rehabilitation service is higher than the England average.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is lower than the England average.
- Average length of stay for non-elective patients in geriatric medicine is higher than the England average.

Average length of stay for non-elective patients in respiratory medicine is higher than the England average.

**Elective Average Length of Stay – Trust Level**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Average Length of Stay – Trust Level</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20171116 900885 Post-inspection Evidence appendix template v3 Page 99
From October 2016 to September 2017 the average length of stay for medical elective patients at Hillingdon Hospital was 10.1 days, which is higher than England average of 4.2 days. For medical non-elective patients, the average length of stay was 7.8 days, which is higher than England average of 6.6 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in clinical haematology is higher than the England average.
- Average length of stay for elective patients in gastroenterology is higher than the England average.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is lower than the England average.
- Average length of stay for non-elective patients in geriatric medicine is higher than the England average.
- Average length of stay for non-elective patients in respiratory medicine is higher than the England average.
Note: Top three specialties for specific trust based on count of activity.

Non-Elective Average Length of Stay - Hillingdon Hospital

(Source: Hospital Episode Statistics)

Across the medical wards, we found there were rooms staff could use to speak to visitors in private or to use to break bad news.

We found that the service had added an additional day at the weekend to address the two-week waits for endoscopy. The unit opened on Saturdays mainly to address this.

Meeting people’s individual needs

There was no learning disability lead for the trust but the service had an agreement with another trust for a learning disability specialist nurse to provide staff with learning disability advice and provide training.

Although the service had guidance relating to providing care to patients with learning disability, we were not assured good practice was embedded in the culture of the organisation in relation to caring for patients with learning disability. For example, during the inspection, a patient with learning disability was cared for on one of the medical wards. A relative told us they had initially been informed they would not be able to stay overnight although this would have helped this patient’s experience in the hospital. We also found that staff had not provided a patient passport or adequately explained to the carer what a patient passport was. The patient passport is a document that provides clear and concise information in an easy to understand format regarding the person’s health and support needs.

The service had a mental health matron who provided advice relating to patients with mental health needs. The service had access to a mental health liaison service through a service level agreement with another trust. Staff could make referrals to that trust for those patients requiring mental health input.
Translation services were available and staff were familiar with the process for booking an interpreter. Translation services were provided via a telephone interpreter and by face-to-face interpreters.

Patient information leaflets on the wards were in English. Staff told us other languages were available upon request. This however meant that a patient who could not read or understand English had to wait before getting the information contained in these leaflets.

The service took part in ‘John’s Campaign’ which is about the right of patients with dementia to have their carers with them in the hospital including overnight.

Staff used ‘Forget me not’ stickers on patient records and on whiteboards to indicate that a patient was living with dementia. This helped improve care by making sure patients got the attention and support that they needed. Staff also used the ‘This is me’ document which is a document intended to provide professionals with information about the person with dementia as an individual in order to enhance the care and support given while the person is in an unfamiliar environment.

There was provision for the needs of bariatric patients. For example, patients had access to bariatric chairs and bariatric commodes.

The service involved external professionals such as general practitioners, local authorities, care home managers and the hospital’s discharge team to support complex discharges.

Access and flow

The service had made improvements in relation to managing the access and flow of patients within the hospital. Following our inspection in 2014, we reported that bed management meetings focussed on getting patients a bed as opposed to getting them a bed on a ward for their speciality. During this inspection, we found that staff demonstrably aimed to get patients admitted to wards reflecting their condition.

Clinical Site Practitioners (CSP) supported the efficient running of the service by ensuring that patients were allocated to the ward that best met their needs. We attended a CSP meeting where staff discussed bed management and allocation. Staff identified patients ready to be discharged by speciality. Staff priority was getting patients on the right wards despite high demand and low capacity at the time of our inspection. CPS meetings took place three times a day.

We observed board rounds where staff discussed patients who were ready to be discharged. This meant that staff could start planning discharges early thus reducing the amount of time other patients would wait to be admitted into a bed. Medical wards worked with A&E to identify patients coming to medical wards early so the right bed could be allocated if available. On the wards, we found that staff also identified patients ready to be discharged during team and safety huddles. For example, on the stroke ward staff identified patients who were deemed ready for discharge and initiated discharge processes quicker which reduced the waiting time for patients being repatriated from hyper acute stroke units.

The service had adopted the ‘Red2Green’ process to help with patient flow within the hospital. The ‘Red2Green’ approach is a visual management system to assist in the identification of wasted time
in a patient’s journey. Patients were reviewed to establish whether anything was holding up their discharge.

In order to manage demand for beds faced by the service, Pinewood, an escalation ward originally intended to be used during the winter months, had remained open indefinitely. When we spoke to the senior leadership team they told us that the plan was to make this a substantive ward.

There was no discharge lounge open at the time of our inspection. The senior leadership told us the previously opened discharge lounge had been closed because of the distance between the lounge and the rest of the hospital. It was deemed inappropriate to send elderly patients to a lounge which they could not easily access.

The service took part in the ‘Discharge to Assess’ initiative in which they worked with community services, social services and the third sector, to develop pathways to support patients in going home from hospital as soon as clinically appropriate. The initiative encouraged teams to think ‘Home First’ for patients who were no longer receiving acute inpatient medical care. Patients discharged in this way received an assessment of their ongoing care needs in their own homes rather than in the hospital. ‘Discharge to Assess’ and the frailty assessment unit on Lister ward focused on getting patients home sooner and safely while improving the flow within the hospital.

Ward teams had access to discharge coordinators within the hospital who helped with complex discharges. Staff reported that delays to discharge were often due to delays in receiving “to take away” (TTA) medicines or transport arrangements.

Although the services had taken action to improve access and flow within the hospital we found that the bed occupancy for medical services was 97% on 6 and 7 March 2018 and 98% on 8 March 2018. This was higher that the bed occupancy at the time of our previous inspection in 2014 where we reported that most of the medical wards had a bed occupancy rate of above 95%.

Between September 2017 and March 2018, 980 patients within the service experienced bed moves between 10pm and 6am. The highest number of moves was on Fleming ward (escalation and coronary care).

From December 2016 to November 2017 the trust’s referral to treatment time (RTT) for open pathways (incomplete) for medicine ranged from 88-98% and was better than the England average for nine out of the 12 months. November 2017 showed 88% of this group of patients were treated within 18 weeks which was the same as the England average. The target is 92%.

(Source: NHS England)
No specialties were above the England average for incomplete pathways (percentage within 18 weeks).

Four specialties were below the England average for incomplete pathways (percentage within 18 weeks):

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoracic Medicine</td>
<td>87.5%</td>
<td>93.3%</td>
</tr>
<tr>
<td>Neurology</td>
<td>83.3%</td>
<td>91.9%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>70.6%</td>
<td>93.5%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>66.7%</td>
<td>97.9%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Ward moves for non-clinical reasons were generally avoided if a patient had already been moved once. However, on occasions, when capacity was limited, the most appropriate admission from assessment areas to specialty wards might require a stable patient to move to another area to create the required capacity.

(Source: Trust Routine Provider Information Request – Ward moves)

Staff told us medical outliers were seen once a day by the medical team unless it was decided that it was clinically appropriate for a consultant on the non-medical ward to review them instead.

The trust had an out of hours policy which staff were aware of and knew how to access.

Learning from complaints and concerns

On some medical wards, leaflets on how to make a complaint were on display. Patients told us they understood how to complain and in two cases patients had used the service’s complaints system. In one case a patient had complained that the ward they were on was cold and at the time of the inspection the heating on the ward had been fixed.

From November 2016 to November 2017 there were 87 complaints about medical care. The trust took an average of 44 days to investigate and close complaints; this was not in line with their complaints policy, which states complaints should be completed within 30 days.

The most prevalent subject matters were:

- All aspects of clinical treatment (General Medicine Group) – 41 (47% of complaints)
- Attitude of staff – nine (10% of complaints)

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Is the service well-led?

Leadership

Medical wards and specialist medical wards fell under the medicine, rehabilitation and emergency care division. Medical services were led by a divisional director, an assistant director of operations,
and five assistant clinical directors (ACD), each for accident and emergency, acute care, acute medical specialities, non-acute medical specialities, and rehabilitation and elderly care.

Ward managers supported by four matrons led the individual wards. There was one matron vacancy in medicine at the time of our inspection.

We found that the leadership (ward level and above ward level) understood the challenges faced by the service. There was alignment between what they told us the top risks were, what we found during the inspection, and the risks recorded on the risk register.

We found that matrons and ward managers understood the challenges to quality and sustainability, and were able to identify the actions needed to address them but did not always have the time or capacity to take those actions. During the inspection senior staff on the wards consistently said that they did not have time to focus on the leadership aspect of their roles because their roles were operationally demanding.

Priorities for ensuring sustainable and effective leadership of the wards were not always clear. For example, Pinewood ward was opened as an escalation ward but had remained open indefinitely. However, the staffing arrangements for that ward had not been stabilised even though senior leadership told us the plan was for that ward to remain open substantively.

Across all wards, staff told us the leadership including the director of nursing, deputy director of nursing and the chief executive were visible on the wards. Staff also told us they felt comfortable approaching them if they had any issues they wished to raise.

We spoke to some staff who said that despite the challenges with low staff numbers, matrons did not help their teams with patient care and staff said this was frustrating. When we asked senior leadership about this they told us that the expectation was that matrons should help staff with patient care on the wards whenever possible. On some of the wards senior staff said they did believe that their management really understood the difficulties they faced in relation to managing a ward with minimal staff.

Vision and Strategy
There was a clear vision and strategy for the trust which was to be an outstanding provider of healthcare. The values of the trust were also clear and embedded amongst staff within the service. The trust values were ‘CARES’ which stands for communication, attitude, responsibility, equity, and safety. Staff in medical services knew the trust values and were able to give examples of how these would apply in their day-to-day roles.

We found that part of the vision for the service was to be inclusive of mental health. A mental health matron had recently been recruited to reflect this.

CARES champions had been recruited and trained to be able to support all staff to challenge inappropriate behaviours and to promote the trust vision and values. The values had been incorporated into the annual staff appraisal so staff would have the opportunity to reflect on their own performance.
The trust’s strategy was aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. The trust was part of the North-West London Sustainability and Transformation plan which sets out how local health and care services will transform and become sustainable.

**Culture**
The majority of staff across medical wards told us they felt supported, respected and valued. Staff also spoke of a sense of pride to work for the organisation.

The culture encouraged openness and honesty at all levels within the organisation. Incident reporting was embedded in the culture of the organisation and staff told us they were encouraged to report incident and did not feel there was a blame culture when they did.

Senior staff understood their responsibilities in relation to duty of candour. Serious incident reports we viewed showed that duty of candour had taken place.

Patients who required or had had the involvement of mental health services were flagged and discussed during handovers to address their needs.

There were mechanisms for providing staff with professional development including appraisals. The results of the staff survey for 2016 showed that staff said appraisal and training were of high quality. Junior nurses had preceptorships and opportunities to rotate within specialities.

Although staff recognised the challenges presented by the aging estate, they were positive and enthusiastic about the care and services they provided for patients.

**Governance**
The service had clear governance processes to provide assurance on performance, safety and risk. Minutes from the patient safety committee meetings fed into the quality and safety committee which in turn fed into the board.

Divisional meetings for medicine took place monthly. Clinical divisional directors, assistant clinical directors, clinical specialist leads, and matrons attended these meetings. Minutes of the meetings showed that agenda items included a review of the risk register, health and safety, infection control, quality management and performance as indicated on the quality dashboards.

Staff at all levels were clear about their roles and understood what they were accountable for and to whom.

**Managing risks, issues and performance**
There were arrangements to identify record and manage risks. The risk register for the service and the corporate risk register contained risks we had identified during the inspection. For example, the registers contained risks related to insufficient nursing staff numbers on the wards, risk to the health and wellbeing of staff because of staff shortages, incomplete or inadequate record keeping, patient falls, out of date policies, and junior doctor cover out of hours. This meant that the
leadership were aware of the risks in the service. Risk registers had been reviewed regularly and mitigating actions put in place.

Although risks had been identified and placed on the risk register, we were not assured that action had been taken to address some of the risks. For example, poor documentation was a risk on the register but on the inspection we still found inconsistencies in relation to the completion of dementia assessments and DoLS documentation. In addition, out of date policies were on the register but we still found outdated copies of the major incident plan on the wards including on the Acute Medical Unit (AMU). We were not assured that the governance and risk management process had been used to effect change and improvement in some aspects of the service.

There was a systematic programme of oversight of actions from clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. For example, the audit and risk committee met quarterly to address internal clinical and non-clinical as well as external audits, the risk register and to challenge adequacy of governance arrangements.

However, we were not assured there was oversight in relation to risks reported on the adverse events reporting system in endoscopy. The reporting system was separate to the reporting system used by the rest of the hospital. Following the inspection, we asked the service to provide us with more information about the adverse event reporting system and how these events were captured, investigated and used for learning. They told us completed adverse event forms were reviewed weekly and discussed at the three-monthly user group meeting attended by endoscopists and nursing staff, and that the clinical lead for the department had complete oversight of the events. They said although adverse events were not reviewed outside of the department, incidents occurring in endoscopy were still reported using the system used by the rest of the hospital. Non-mental health staff that were not competent or confident in working with people’s mental health or emotional needs had access to a mental health matron as well as a mental health liaison service.

Information management
Staff reported they had adequate computer systems to allow them to carry out their job roles and effectively document patient records. Staff also had access to information such as policies and procedures on the trust intranet.

There were clear service performance measures which were reported and monitored via the use of the quality dashboard or balanced scorecard.

We found that the service was not always able to submit into all national audits because the computer systems and programmes did not always support the submission of collection of data for all audits.

Engagement
Following the most recent staff survey, the trust launched a ‘You Said, We Did’ exercise in order to assure staff that their views were listened to. For example, in response to feedback that career
progression in the trust was not equal the trust implemented the ‘Ready Now’ programme where there was recruitment of senior staff from black and minority ethnic backgrounds.

The trust had created ‘CARES’ champions to address staff concerns around bullying and violence form other staff and service users.

A number of staff award schemes were available. These included a staff reward and recognition scheme including monthly staff awards presented by executive directors and a staff to staff rewards scheme. The trust also had annual staff awards.

To engage with the public, the trust had quarterly council of governor meetings and took part in, patient and public forums. There was engagement with volunteers and user and support groups such as the Fighting Infection Together group.

The trust also worked with community partners and clinical commissioning groups to enhance communication for patients both during and after leaving hospital.

**Learning, continuous improvement and innovation**

There were initiatives to work with community partners in order to encourage early and safe discharge from hospital and reduce length of stay. The ‘Home Safe’ initiative helped elderly patients get early discharge to their homes with community support.

Following the previous inspection, the AMU had now been complete. This also included a new endoscopy unit.

On each ward, a noticeboard included a poster where a topic for the month was selected as part of learning and continuous improvement.
Surgery

Facts and data about this service

The trust had two operating departments. The Hillingdon hospital had seven main operating theatres covering mixed emergency/trauma and elective surgery. The hospital had two surgical wards; Kennedy and Jersey ward. Gynaecologist patients that required surgery were looked after in Pagett ward. Patients were also cared for in the acute surgical unit, the female day care unit, and the male day care unit. the surgery division had 109 inpatient beds.

The trust serves elective and emergency admissions apart from hepato-pancreato-biliary (hpb) and sarcoma surgery; delivering surgery across two sites, with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and trauma lists being run at the Hillingdon site.

The trust collaborates with national and local partner organisations to deliver paediatric, neurosurgery, trauma, urological & upper gastrointestinal cancer services and runs surgical lists for ENT/Maxo facial outpatient surgery, ophthalmology, chronic pain, benign urology conditions, dermatology, colorectal & breast surgeons.

(Source: Routine Provider Information Request (RPIR) – “Sites-Acute” tab)

The trust had 14,606 surgical admissions from October 2016 to September 2017. Emergency admissions accounted for 4,436 (30%), 7,812 (54%) were day case, and the remaining 2,358 (16%) were elective.

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The trust set targets between 80-95% for completion of mandatory training.

A breakdown of compliance for mandatory courses from April 2017 to November 2017 for all staff at Hillingdon Hospital in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained (YTD)</th>
<th>Number eligible (YTD)</th>
<th>Completion (%) YTD</th>
<th>Target Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>90%</td>
<td>81</td>
<td>83</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>80%</td>
<td>80</td>
<td>85</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>80%</td>
<td>454</td>
<td>494</td>
<td>92%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>80%</td>
<td>447</td>
<td>494</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Five of the 13 mandatory training modules failed to meet the trust target. Manual handling had the lowest completion rate with 64% compared to the trust target of 80%. During our inspection, we observed poor manual handling in the wards. For example, we witnessed patients being transferred between beds using a bed sheet rather than a slide sheet. We witnessed staff kneeling on the bed to pull patients across. We also saw a nurse assisting a patient from their bed to a chair with poor posture. The nurse bent down without bending their knees. In this instance, we witnessed no forward planning and the nurse got themselves trapped between the patient’s leg and bed.

In theatres however, we observed the correct use of slide sheets to transfer patients and good compliance with manual handling. There was good compliance for completing training in theatres and Pagett ward.

Managers were able to access outstanding training modules for staff through a computer programme and inform their staff of outdated training modules.

We requested additional data from the trust on sepsis training and advanced life support training, but this was not received.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Safeguarding
The trust set targets between 80-90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April 2017 to November 2017 for all staff at Hillingdon Hospital in surgery is shown below:
Safeguarding Children (level 2) failed to meet the trust target. The remaining three safeguarding modules met the trust target. We spoke with staff regarding their safeguarding training and staff was unsure if they had completed this. We observed a paediatric patient in recovery next to an adult patient during our inspection. We raised this with staff and we was informed that that paediatric patient was kept to end of the recovery unit.

(Source: Trust Provider Information Request P18)

**Cleanliness, infection control and hygiene**

Theatres we inspected were visibly clean and safe. Cleaning schedules were in place and there were clearly defined roles and responsibilities for cleaning and decontaminating equipment, and for cleaning the environment. We observed theatre staff cleaning the theatres between patient cases.

However, wards that we observed were visibly dirty; we observed dust under the beds, heavily stained floors and noticed an odour in all the surgical wards we inspected. The trust used their own domestic staff for cleaning the wards. The trust did not use any methods such as ‘I am clean’ stickers to indicate when equipment was last cleaned. We observed a thick layer of dust on the patients weighing scales. We observed high-level dust in Kennedy ward particularly on the top shelf of the linen cupboard. The ward sister on Pagett ward raised concerns with the cleaning rota. This ward only had a cleaner for four hours during the day shift and one hour during the night shift. The surgical matron had also acknowledged these concerns. We observed a cleaning template on the wall indicating how often the ward should be cleaned however, there was no cleaning rota signed to evidence cleaning.

In Jersey ward, the wall cupboard in the sluice was not locked and contained chlorine tablets. This contravenes the Control of Substances Hazardous to Health Regulations 2002. We inspected the sluice rooms in the surgical wards; all sluice rooms did not have a lockable door. In Kennedy ward there was a strong odour in the sluice room. We also saw that the stainless steel sink and hopper was heavily stained with lime scale and did not appear clean. We also found a named patient’s cream within the cupboard. We observed a health care assistant entering the sluice, use the incarcerator and leave without cleaning their hands. We observed staff carrying a washbowl full of urine from a patient’s bedside to the sluice. The washbowl did not have a cover and the nurse did not wear an apron; only gloves were worn. In the female day care unit, we found six cardboard kidney dishes filled with patients’ urine. We saw that each kidney dish had just the patient’s bed number written in pen, to identify which kidney dish belonged to which patient. This was the method used for testing for pregnancy. We spoke to the nurse in charge who told us that they were not happy with the process but that it was always done in this way. This method had a significant margin for error.

Personal protective equipment such as gloves and aprons was available for staff to use. They were conveniently located outside patient bays, individual side rooms and above hand washing sinks. However, in Kennedy ward we found three apron dispensers were empty. We observed staff dressing according to the dress code policy, hair was worn up and jewellery was kept to a minimum. All staff in wards we observed were bare below the elbows. However all staff wore I.D badges on lanyards around their neck which were touching patients when they were providing patient care. We did not observe doctors adhering to the infection control guidelines in theatres,
and many doctors gathered in the theatre corridors without wearing scrubs or shoe protectors. We also observed staff wearing jackets and long sleeved cardigans over uniforms in the theatre main corridor when collecting patients. Furthermore, there was only one exit and entrance to theatres. This means there was a potential cross contamination issue when ward staff visited the theatres.

We observed staff using hand sanitiser gel before and after patient contact on Jersey ward and in theatres. We did not observe this on Kennedy ward. On Kennedy ward, we observed a doctor and a nurse enter a side room for a barrier-nursed patient without gloves or gowns despite the warning sign on the side room door.

We observed that each observation machine had a packet of alcohol wipes, used to clean the reusable cuff for measuring blood pressure. On Jersey ward, we saw that the cuff was wiped after used however, on Kennedy ward the cuff was not wiped after use. We were informed that infectious patients had their own cuffs whist on the ward.

We observed that disposable curtains around individual patient beds were clean and were all in date. However, we saw non-disposable fabric curtains that were frayed, being used in the shower room. We also saw non-disposable fabric curtains in a consultation room, which were visibly dirty.

There were safe arrangements for the handling, storage and disposal of clinical waste, including sharps bins. We observed sharps bins that were not securely kept on the ward, and left opened on top of a trolley, that had wheels. There was also poor compliance in the use of the temporary closures of the sharps bin, which is highlighted in HTM 07/01 The Safe Management of Healthcare Waste 2013.

We observed general and clinical waste bins in each bay and in the corridors of the wards. These bins were not overfilled and were labelled clearly. However, on Jersey ward we did observe blue gloves in a domestic waste bin, which should have been placed into a clinical waste bin.

We saw that in some of the clinical waste bins there were items that should have been disposed of in the incarcerator. On Kennedy ward, there was a domestic waste bin outside bay three that was foot operated but could not be opened.

In theatres, we saw clinical waste appropriately bagged and tagged after surgery but these were stored in bins in the main corridor. These bins were removed every 20 minutes and taken to the dirty waste storage area in the theatre.

We observed a new sterile set area, in an area off the main corridor. However, there were trolleys and bed outside theatres that had no indication if they were clean or dirty. Theatre doors in sterile areas were damaged and were not closing fully which could lead to a compromise in infection control. The hospital had already replaced theatre doors one and six. We were informed of a door project that would ensure that the five remaining doors were going to be replaced as well. We observed a patient being brought into the main theatres on a hospital wheelchair and not on a theatre wheelchair. This was escalated to a band seven nurse who told us that this was normal practice. This practice compromises infection control. We also raised this to the infection prevention control lead.

The trusts water quality group (WQG) monitors the buildings compliance with current water systems legislation and guidance. The WQG had reported high legionella counts from the trust on
a reoccurring basis. In the financial year of 2016/2017 the trust spend £828.8k to improve the condition of the water such as installing new water softeners, and replacing the boost water tank hollow lid supports. In surgery, taps within the theatres and wards were fitted with pseudomonas filters that required changing once every two to three weeks.

There were no separate lifts for patients, during the inspection we shared lifts with clinical and domestic waste, dirty dishes and opened waste food bins on trolleys.

**Environment and equipment**

In pre-assessment, we looked at six blood pressure machines two of these machines did not have in date portable appliance test (PAT). The fridge in pre-assessment was due a PAT test in 2016. We looked at two weighing scales, one resuscitation trolley and an oximeter that all had in date PAT tests. Theatres stored a list of their equipment on an assets register and all equipment had valid PAT tests.

The surgical assessment unit (SAU) was dividing singular bed spaces into two patient bed spaces, with the use of screens. The division meant that only one patient had access to oxygen, suction and the call bell. Staff we spoke to on SAU informed us that this procedure had been occurring since January, and had raised this concern to the trust. The trust stated that only carefully selected patients were being placed in these beds. Therefore this practice continued. However, during our inspection on the female SAU we saw that an elderly patient was put into a divided bed space. This patient was not independent and required assistance to transfer from bed to chair from two members of staff. This patient was frail had did not have access to the call bell, oxygen or suction. This patient had access to a hotel style bell, but this bell was out of arms reach. On the male SAU we saw another singular bed space split into two patient bed spaces. One of these bed spaces had a patient that had just returned from theatre and was still very drowsy from the anaesthetic; this patient had no access to a call bell, oxygen or suction. We raised this with a nurse who simply shrugged their shoulders. The sister on the ward was also notified but no effort was made to provide the post-operative patient with a call bell. We raised this issue immediately with the trust chief executive who undertook to investigate this matter.

Surgical wards were easily accessible, and anyone could walk in unchallenged. On entry to the surgical wards, there were many signs that stated; ‘no entry staff only’. However, the doors were not fitted with secure entry systems. Once entering a ward the doors would lock and exiting the ward was difficult. Patients, relatives and staff were required to input a code into a keypad by the door to exit the ward. We observed many patient relatives struggling to exit the ward. The lack of staff in Kennedy ward meant that it was difficult to track someone down to gain the code.

We observed that all surgical wards were mixed sex wards; however, there were single sex bays within the ward.

We observed that Kennedy ward had six side rooms. The doors to these rooms opened inwards and there was no privacy curtain in place. Therefore, it was possible to compromise a patient’s privacy and dignity.

We observed poor flooring throughout the surgical wards particularly underneath windows on Kennedy ward. Flooring in the female day unit was particularly poor and we observed patchwork
flooring along the main corridor. The damage had compromised the integrity of the floor covering and could not be cleaned or disinfected effectively.

We observed that gaffer tape was being used on the windows to prevent draft; we had observed this during our last inspection, in Kennedy ward. There was also gaffer tape being used in one of the theatres. We were told that the tape had been replaced but there was no long-term solution in place to mitigate this. Patients we spoke with that told us that the wards were cold during the snow as the heaters did not work at this time. Patients we spoke with told us that they had brought in their own blankets from home and their own heaters. These heaters were not PAT tested. In pre-assessment staff reported that there was particular assessment room that was very cold but they still need to use this room, as there were not enough consulting rooms.

We observed the kitchen doors to both Jersey and Kennedy ward had a keypad entry but these doors remained opened throughout our inspection. The kitchen area in Jersey ward was generally rather untidy and we observed loaves of bread lying on the work surfaces. The kitchen in Kennedy ward was clean and tidy.

In Kennedy ward, the resuscitation trolley was difficult to push. We found the wheels sticky, which meant that it would be difficult to push the trolley quickly in the event of an emergency. In the female day care unit, staff informed us that the resus trolley was constantly being moved about. It is important that the resuscitation trolley remain in a place that is easily assessable and staff know where this is at all times Trolleys were locked with a breakable seal, which demonstrated the trolley had not been opened or equipment used or tampered with since it was last used. Records we looked at showed that the resuscitation trolleys were all checked daily with stocks of equipment and consumables maintained by staff. In Jersey ward the surface of the trolley was messy and we observed many old defibrillator testing strips wedged by the side of the defibrillator. However, we observed gaps in the daily recording of the resuscitation trolleys in recovery unit and we raised this to the theatre manager. We were told that since November 2017 the resuscitation trolley had been taken out of recovery and used in theatre for patients with cardioversion. This meant that recovery did not have access to a resuscitation trolley on these days and that checks were not performed on the days these surgeries took place. The theatre manager did not know if this had been identified on the risk register. We requested additional data post inspection and found that this was not recorded on the risk register.

In Jersey ward, we observed a stethoscope left hanging over a fire press button. We saw a walking frame, two blood pressure machines and a dusty floor mop obstructing the fire extinguishers outside bay one in Kennedy ward.

Slide sheets were not readily accessible. We ask to see where the patient slide sheets were kept. These are tools commonly used to aid a patient to transfer from one bed to another. The ward manager had to go off the ward to locate these slide sheets, which meant that they were not easily accessible. The pat slide, commonly used in association with the slide sheets was clean and readily available. The hoist was broken and had gone for repair, therefore Jersey ward was sharing a hoist with Kennedy ward.

We saw maintenance work being carried out in Jersey ward. The floor under the sinks in the corridors was being replaced. We saw appropriate yellow ticker tape and signage to warn people of the risk of the uneven flooring. However, the maintenance work within theatres, caused dust and disruption to sterile environments whilst there was still a theatre list to complete; causing a
potential infection control issue. We escalated this to the band seven nurse in charge and the theatre manager was notified. This incident was reported on the electronic reporting system.

We observed a physiotherapist using a commode as a wheelchair. We observed the physiotherapist walking with a patient who was using a waking frame. The patient was unsteady and the physiotherapist was pulling along a commode with the lid on with the bedpan underneath visible. When the patient needed to sit down the physiotherapist helped the patient onto the commode.

Despite the updates since the last inspection and making major improvements costing £1.5 million, the theatre ventilation remained on the risk register. This was because the ventilation was not up to date with current guidelines due to the age of the building. The theatre ventilation was checked and airflow filters were replaced on a monthly basis, on audit days when no lists were planned. An external contractor checked the air quality in every theatre annually. Each theatre was closed for one week per year for maintenance work during the summer period.

All sterilisation of equipment was outsourced, and the trust had the ability to fast track items within four to six hours if necessary. The hospital did not report any issues with lost equipment. The hospital had maintained a good relationship with other sites nearby in case emergency equipment was required. All equipment in theatre conformed to the national safety standard and aesthetic equipment complied with the Association of Anaesthetics of Great Britain and Ireland (AAGBI) guidelines for checking anaesthetic equipment 2012. Consultants we spoke with reported that equipment was good and modern and that registrars approve of this, as the equipment was good to learn with. The hospital had lead aprons available on hangers, which were all intact with no rips, ready to use for interventional radiology surgery.

We observed a lack of storage in theatres. This was in despite of improved storage facilities. Equipment lined the corridors such as wheelchairs, stats machines, and operating trolleys.

**Assessing and responding to patient risk**

There was no assurance that patients with Methicillin Resistant Staphylococcus Aureus (MRSA) were identified early at the time of pre-assessment. Staff we spoke with in preadmission informed us that patients who were previously MRSA positive were in the high-risk group. According to the MRSA policy, these patients must be screened for MRSA at pre-assessment. We looked at the pre-assessment questionnaire, which did not include questions on previous infections, such as MRSA clostridium difficile and E.coli. Therefore, this meant it was difficult to ascertain which patients fell into a high-risk category.

Staff we spoke with on Kennedy ward were unable to recall the bleep number for the critical care outreach team but knew where to find this information. This team is a specialist critical care team set up to support clinical staff in managing acutely ill patients in hospitals to improve outcomes for ill patients. This team provided care and advice for critically ill patients but was only available Monday to Friday 8am to 4pm and. This risk was documented on the surgical risk register. The team also provided teaching sessions, which was well received by staff.

A National Early Warning Scores (NEWS) system was used to monitor patients, and this provided clear guidance on the process to follow for escalation to medical staff including the outreach team.
Staff we spoke with knew whom to bleep and they would state the patient's name, hospital number, the patient's consultant and the name of the ward. A new process was put into place whereby a NEWS score between five or six would require bleeping a Senior House Officer (SHO). We observed clear documentation in patients' notes of a senior medical review after a high NEWS score. SHO's reported that this system was not feasible when they were on call. This was due to the sheer number of bleeps that affected their work productivity.

There were no pathways used for identifying sepsis at the hospital. We asked a nurse on Kennedy ward if patients were routinely screened for sepsis. The nurse assumed that this was done on admission in accident and emergency. We looked through the patients notes together but we could not locate a sepsis screening tool. The nurse we spoke with did not know whether this was a tick box on an admission form or whether it was another specific screening tool. We spoke to a ward matron who told us that patients should be assessed for sepsis, but showed no awareness of the sepsis six bundle. The sepsis six is the name given to a bundle of medical therapies designed to reduced mortality of patients with sepsis. The matron we spoke with told us that sometimes patients with sepsis were missed, as assessments were not fully established. We spoke to a doctor on the ward regarding sepsis, we were told that identifying sepsis was doctor driven and that there was no onus on the nurses for sepsis. We requested sepsis data on polices and training. The hospital sent back an inpatient sepsis screen and action tool. This was not seen during our inspection, even when we prompted nurses for this information.

On numerous occasions, we observed the nurse call bell ringing for more than five minutes before assistance was offered to patients on the wards. This was in direct contradiction to the call bell standards on display at the ward entrance. This stated that calls were answered within two minutes and never rang more than five minutes. This was clearly a direct result of the lack of staff on the ward.

We observed in patient notes that care assessments were used across the hospital included a risk assessment. These assessments included manual handling, pain relief, the waterlow score, pressure ulcers, malnutrition and pain. If the patient was at high risk then a care bundle package was put in place, for example a skin bundle to reduce pressure sores. Venous thromboembolism (VTE) is a condition where a blood clot forms in a vein. Patient records showed that VTE assessments were being carried out and mitigating actions were put into place for those patients at risk of a VTE. An audit conducted between January and February 2017 showed that 100% of patients had completed VTE assessment on admission. Appropriate actions was implemented with stockings for 97% of patients and with heparin for 100% of patients.

We spoke to staff on the wards who told us that there was no Local Safety Standards for Invasive Procedures (LocSSIPs). Staff we spoke with did not understand this terminology. Theatre staff understood what National Safety Standards for Invasive procedures (NatSSIPs) were. Theatre staff told us that they followed the WHO safety checklist, which was reviewed and updated, and that dental and oral surgery required a new LocSSIP checkli

In theatres, we observed the World Health Organisation (WHO) five steps to safer surgery checklist completed before each surgery. Patients' ID and procedures were verified before starting. We observed the theatre room time out completed by the consultant surgeon. We observed nursing staff checking allergy status for each patient. If a patient had an allergy, a red band was placed around the patient's wrist. We also observed a board in theatre that listed the
patient’s details and allergy status. We also observed the WHO surgical checklist used for radiological interventions. We observed formal briefings, as per the WHO guidelines, that were conducted before the start of a trauma list. We observed surgeons present at this meeting. However, debriefings were not as formal and we observed consultants and anaesthetics leaving the meeting before it had finished.

**Nurse staffing**

Wards in the surgery division were short staffed. The ward manger on Kennedy ward was on annual leave during our inspection. Therefore, we spoke to the nurse in charge on Kennedy ward regarding staffing levels. We requested to look at the staff roster to observe the skill mix. However, the nurse in charge did not have access to the electronic rota system and we were unable to view this. Staff we spoke to told us that the ward clerk would print the rota daily. Staff we spoke with informed us that the highest-grade staff on the ward during the day would be a band 6; this would sometimes drop to a band 5 during night shifts. On the days of our inspection Kennedy ward had one full time band 6, one full time band five and three agency staff. The nursing establishment on this ward should be five trained nurses and three HCA’s. The nurse in charge reported that tasks were difficult to complete with agency staff that were not regular to the ward. However, the ward did have a few agency staff that were regular that made tasks easier. Agency staff we spoke to that was regular enjoyed working on the surgical wards. We requested additional data on staff rosters from the trust post inspection. We found that Kennedy ward had 22 unfilled shifts for registered nurses between the 04 February and 17 March 2018. There was also four unfilled shifts between this time period for HCA’s. Jersey ward had 19 unfilled shifts during this period and the surgical assessment unit had 24 unfilled shifts during this time.

Surgical wards displayed contact details for link nurses such as; diabetes, nutrition, tissue viability and infection prevention control.

Theatre rotas showed a lack of band five nurses and senior staff admitted that they were struggling to recruit this grade of nurses. However, rosters in theatre reflected safe standards and adhered to guidance in the Association for Perioperative Practice.

The Hillingdon Hospital reported their staffing numbers below for the period April 2017 to November 2017. Nursing staff reached 83% of planned capacity as at November 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Planned Staff</th>
<th>Number in post as at November 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Hillingdon Hospital</td>
<td>160.2</td>
<td>133.7</td>
</tr>
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</table>

*(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)*

From December 2016 to November 2017, Hillingdon Hospital reported a vacancy rate of 22% in surgery for qualified nursing staff, compared to the trust target of 8%. A recruitment dive was in place to attract staff, such as supporting overseas nurses through their nursing and midwifery council registration processes.

*(Source: Routine Provider Information Request (RPIR) P17 Vacancies)*
From December 2016 to November 2017, Hillingdon Hospital reported a turnover rate of 17% in surgery, compared to the trust target of 13%. Staff we spoke to said that the location of the hospital was a large factor for the high turnover.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From December 2016 to November 2017, Hillingdon Hospital reported a sickness rate of 4% in surgery for qualified nursing staff, compared to the trust target of 3%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Surgery had 10,196 shifts filled by bank and agency staff, which was the second highest core service uptake within the trust.

The trust did not provide accurate data for the total number of shifts overall and therefore we are unable to calculate the total number of shifts covered by bank and agency and the number of shifts left unfilled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing
We observed no gaps in the junior doctor rota; trust grade doctors always covered unfilled shifts. However, there were not enough junior doctors to ensure the completion of mandatory training. Medical staff we spoke to reported that they had been pulled out of mandatory training to fill shifts; this meant that some doctors we spoke with had not even completed their induction training.

Junior doctors felt welcomed into the surgical department and reported the hospital as a friendly place to work. Junior doctors felt that their seniors were very approachable, had regular contact with their seniors and were able to go to theatres.

Specialist registrars (SpR) performed daily ward rounds for inpatients on surgical wards. Doctors reported that they were able to ask questions during ward rounds. These patients were not reviewed daily by surgical consultants. There was delegated surgical teaching timetabled weekly, although these teachings were sporadic. There were however, protected weekly teaching where bleeps were taken away from medical staff. Medical staff also had access to the library and IT facilities in the education centre in the hospital. Junior doctors were encouraged to participate in audits and present them at monthly governance meetings.

Overall doctors finished their shift on time, however when doctors were on-call doctors left late frequently due to late reviews. Junior doctors felt that they were expected to swap their days off when their mentoring consultant was on call as they were expected to be present. This meant that some junior doctors were working seven, eight or nine days in a row. As a result, doctors were working beyond the expected safe working hours by working long stretches of consecutive days. We spoke to the junior doctor guardian of safe working who was not aware of the situation but was going to follow it up with medical staffing and the junior doctors locally as this was not acceptable.

Medical staff we spoke with said that all doctors working in the trust were covered by the trust’s own medical indemnity insurance. Doctors were encouraged to have their own indemnity cover,
but this was not compulsory. Consultants we spoke to were supported with their General Medical Council (GMC) revalidations and they were in date.

The Hillingdon Hospital reported their staffing numbers below for the period April 2017 to November 2017. Medical staff reached 89% of planned capacity as at November 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Planned Staff</th>
<th>Number in post as at November 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Hillingdon Hospital</td>
<td>176.6</td>
<td>156.3</td>
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(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From December 2016 to November 2017, Hillingdon Hospital reported a vacancy rate of 8% in surgery for medical staff, which was the same as the trust target

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From December 2016 to November 2017, Hillingdon Hospital reported a turnover rate of 11% in surgery, compared to the trust target of 13%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From December 2016 to November 2017, Hillingdon Hospital reported a sickness rate of 1% in surgery, compared to the trust target of 3%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The trust did not provide accurate data for the total number of shifts overall and therefore; we are unable to calculate the total number of shifts covered by bank and locum and the number of shifts left unfilled.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

In September 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was the same.

**Staffing skill mix for the whole time equivalent staff working at The Hillingdon Hospitals NHS Foundation Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>45%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>19%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>25%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>11%</td>
<td>11%</td>
</tr>
</tbody>
</table>
Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records
We looked at 39 patient records in the surgical wards. These records were kept in a keypad locked trolley and kept in the ward corridors. In general surgery patient folders were not well kept and the older the file, the more unkempt the folder appeared. However, notes were clearly written and all entries within a patient’s set of notes were dated and signed (names were not printed). We saw that some pages were not filed away securely and had been torn from its binder, in additional we saw that not all extra continuation sheets added to a patient folder had a patient ID sticker attached. This meant that it could be easy to loose parts of a patient’s record or that notes could be misfiled. We found a set of patient stickers in one set of notes belonging to a different patient.

Patients’ notes we looked at showed clear transfusion records that included the prescribers name and signature and appropriate observations. We observed clear instructions for dressing a leg ulcer with a chart and diagram. Observation charts were neat and regular observations were recorded. Each patient had a stool chart completed using the Bristol stool chart. We observed that a falls assessment had completed along with other assessments such as water-low, skin, bed rail, manual handling and malnutrition for each patient.

There was a dual process for record keeping within the division. Each patient had a set of hand written records and an electronic patient record. Only permanent members of staff could access the electronic records and were required to update the electronic record. This meant that on one particular day the nurse in charge on Kennedy ward had 31 records to update. The electronic record could be accessed via an electronic tablet that permanent staff members wore over their shoulder. We looked at these records, which showed simple displays of information such as patient name, bed location, and text copied from written records. NEWS, VTE or any other patient safety indications were not displayed at a glance.

On Jersey ward in an unlocked room, labelled ‘Admissions and Discharge Nurse/ Quiet Room’ was a set of occupation therapy notes lying open the desk unattended. We were able to gain access to patient’s details, including diagnosis and addresses. The notes were left unattended for a further 20 minutes until a specialist advisor gave the notes to a staff member on the ward. On Kennedy ward, we often found notes left unattended at nurse’s stations. We observed a member of staff leave their computer screen unattended whilst they were walking around the ward. This meant that patient information such as name, addresses and medication was left on display.

Medicines
Medicines, including controlled drugs, were securely stored and staff checked stocks of both medicines and controlled drugs (CD) daily. We looked at CD audits in Kennedy ward and Jersey ward. The audits were completed by staff in pharmacy. The audits were not concluded and did not provide a percentage of compliance. Where wards were not compliant, we did not see any documentation to suggest improvements.
Staff we spoke with knew how to discard of CDs correctly. Medicines were in good condition and records were completed accurately. We found one loose strip of pills not in a box, but the trolley was generally tidy, clean and alphabetically organised. We found two out of date medications inside the trolley on Jersey ward. We informed the sister on the ward who disposed of this medication immediately.

We visited Kennedy ward and female day care and looked at nine medicine charts. Staff completed the medicine prescription charts and administration records accurately. The majority of medicines and intravenous fluids were stored securely. However, on the female day care unit, there was no treatment room and therefore intravenous medicines were prepared on a low work surface behind the nurse’s station. Furthermore, on the female day care unit we saw prescription only medicines on a patient table, as there was no lockable bedside cupboard and no space in the stock medicine cupboards. The ward sister said that she did not have any other option for storing patient’s own medicines safely.

The ordering, storage and administration of controlled drugs was in accordance with the Misuse of Drugs Act 1971 and the associated regulations. Wards visited had suitable cupboards to store controlled drugs. Staff recorded fridge temperatures daily and records showed that refrigerated medicines were stored at appropriate temperatures. Room thermometers had been installed in treatment rooms but staff was not recording the temperatures. Staff said that recording of room temperatures would commence in March 2018.

Oxygen cylinders were not checked regularly to make sure they were at least at least three-quarters full. We found an oxygen cylinder in stock in the female day care unit was less than half-full.

The pharmacy staff checked (reconciled) patients’ medicines on admission to wards however; the hospital only did this check for 50-60% of patients within 24 hours of admission to hospital. The trust’s key performance indicator was to complete medicines reconciliation for 100% of patients within 24 hours of admission to hospital. The chief pharmacist thought that a pharmacist was visiting the female day care unit when beds were used for inpatients. However, the ward sister said that they did not get a visit from a pharmacist and there was no medicine reconciliation documented on six out of six prescription charts seen. The trust recognised this as a risk, which was documented on the pharmacy risk register.

The trust planned to recruit two more pharmacists to support a seven-day clinical pharmacy service. There were six inpatients on the female day care unit that had not had their medicines reconciled. While nursing staff did medicine training and competency assessments at induction, the trust did not have an education programme for update medicine training. We spoke with nurses who had been working in the trust for more than five years and had not received medicine training since their induction.

Incidents

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
From December 2016 to November 2017, the trust reported one incident classified as a never event which was for surgical invasive procedure incident meeting SI criteria for surgery: 2017/11952/RAS - Wrong power of intraocular lens inserted during cataract surgery.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported seven serious incidents (SIs) in surgery, which met the reporting criteria set by NHS England from December 2016 to November 2017.

Of these, the most common types of incident reported were:

- Surgical/invasive procedure incident meeting SI criteria with two (29% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with two (29% of total incidents).
- Treatment delay meeting SI criteria with one (14% of total incidents).
- Operation/treatment given without valid consent with one (14% of total incidents).
- Slips/trips/falls meeting SI criteria with one (14% of total incidents).

Site specific information can be found below:

The Hillingdon Hospital: three incidents:
- 2017/16038/RAS - Sub-optimal care of the deteriorating patient meeting SI criteria
- 2017/18562/RAS - Treatment delay meeting SI criteria
- 2017/2276/RAS - Operation/treatment given without valid consent

(Source: Strategic Executive Information System (STEIS))

The most recent never event that occurred within surgery was a retained swab inside a patient post surgery. This incident was reported on the electronic reporting system and all staff were aware of this incident. The department revised the swab policy and now swabs were bagged in groups of five. This was now standardised procedure for this hospital.

Staff we spoke to knew how to report incidents, which were recorded on an electronic database. Staff were familiar with the database and all incidents were reviewed by the ward manager. Staff reported that patient falls and staff shortages were reported as incidents. Staff we spoke to knew of investigations that occurred from reporting incidents and root cause analysis was actioned and fed back to staff by the ward manager, through staff meetings. Staff reported that they were kept informed about incidents from other divisions within the hospital, such as drug errors. The last serious incident in the hospital was shared amongst all staff, a patient was admitted and vital...
signs had not been checked for the patient, this resulted in the patient becoming critically ill. Staff were told about this incident to ensure and remind staff that vital signs should be checked when a patient are admitted to the hospital.

Staff we spoke with on Kennedy ward, Pagett ward and in theatres understood a duty of candour and could provide examples of how and when to apply them. Duty of candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide appropriate support to that person or persons. Staff we spoke with in pre-assessment did not know what a duty of candour meant or transparency. There was no duty of candour policy found on the intranet. The online electronic reporting system did promote a duty of candour and did not have a trigger or an area to document that this duty had been applied.

Safety thermometer
The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer, no falls with harm and nine new catheter urinary tract infections from December 2016 to December 2017 for surgery.

Prevalence rate (number of patients per 100 surveyed) of total catheter urinary tract infections at The Hillingdon Hospitals NHS Foundation Trust

![Graph showing prevalence rate of total catheter urinary tract infections (CUTIs) from March 2016 to December 2017.](Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment
We looked at the polices for pre-operative fasting, MRSA and anticoagulants which were all per national guidelines. There was no local pre-operative test policy in place; however, the hospital used the latest National Institute for Health and care Excellence (NICE) guidelines from 2016. The hospital had up to date NICE guidelines on stopping angiotensin-converting enzyme (ACE) inhibitors as per NICE guidelines.
Staff we spoke with were not aware of any pre-admission policy in place. Staff we spoke with knew they were required to tell patients to stop certain medications before procedures such as diuretics and insulin but staff could not locate this policy. Hospitals must have local guidelines that define the management of chronic medication pre and post operatively, including while nil by mouth. This guidance must include advice on the management of heart medication, diabetes, medication of dependence, antiplatelet medication/warfarin and non-prescribed medication as per the guidelines of the Royal College of Anaesthetists. The hospital did not ask patients to stop certain blood pressure medication as per national guidelines. Staff we spoke with in pre-assessment said that there was no time to write a policy or to look up a policy on the computer, and that this was a job for a band seven. Anaesthetic staff were working on new guidelines but junior staff were not involved in creating these polices and protocols.

We spoke to an agency staff member who was not aware of any activity or dependency audits to record or monitor patient care needs on the ward. Senior levels of staff told us that the surgery division did not undertake any benchmarking exercise with other similar services.

The hospital did not audit the World Health Organisation (WHO) five steps towards safer surgery in 2017. The assistant director of nursing said that it did not make sense to complete an audit that was under reconstruction, due for completion in April 2018. We looked at previous WHO five steps towards safer surgery checklists in patient records and found that three out of four checklists were not completed.

However, the WHO surgical safety checklist for radiological interventions was audited by a consultant radiologist. The audit included clear recommendations of improvements for staff on how to perform better.

An audit on clinical effectiveness found that care plans were not completed properly; mitigating solutions were documented but not put in place. A harm free care audit was conducted across two wards; results showed that no harm was identified within the division. Peer audits took place between each theatre and a band seven was responsible for this. This new initiative had been developed and well received. These audits covered environment, safety, infection control, equipment and documentation. The hospital participated in the national confidential enquiry into patient outcome and death (NCEPOD). We saw checklists in the anaesthetic room that showed safety guidelines for anaesthetic equipment in line with the Association of anaesthetics of Great Britain and Ireland (AAGBI). Breast reconstruction surgeries began in 2017 at the hospital; the breast surgeons held the responsibility to update the breast implant register and verbally informed the theatre manager when this was done.

**Nutrition and hydration**

We observed that patients had protected meals times on wards between 12.30pm -1.30pm and 5pm to 6pm. This information was displayed at the wards entrance. Inside the kitchen on Kennedy ward, we found two yoghurt pots in the fridge, which were both past their “best before” dates. Dietary needs were displayed above patient’s bed. We spoke to housekeeper staff in the kitchen that was aware of this and liaised with nurses if there were any changes to diets displayed.
We observed a patient’s relative raise concerns that their family member had not eaten their lunch, as the patient was not assisted in sitting up in Kennedy ward. A member of staff was heard saying ‘oh well we tried our best’. We did not observe staff offering any other alternatives. The patient’s record stated that only two cups of tea and a banana had been consumed between 8am and 3.15pm. We looked at another patient’s fluid balance chart, which documents a patient fluid movement in and out of the body. We saw that there was no documentation for more than 4.5 hours despite the patient having a catheter and intravenous fluids. It is important to monitor a patient’s fluid intake and output if they are at risk of fluid imbalance or dehydration. We did observe a HCA providing a straw for a patient that had difficulty drinking in Jersey ward.

There were no pre-operative fasting audits for patients fasting before surgery. The lack of auditing in this area meant that the hospital did not know if they were adhering to their own starvation policies. Excessive starvation can result in hypoglycaemia risks to the patient, long starvations times should be documented in the risk register. We requested additional data post inspection and found that this was not recorded on the risk register.

**Pain relief**

Staff used a recognised tool based on a numeric rating scale to assess patients’ pain and the effectiveness of pain relief. This tool asked patients to score their pain from zero to 10, with zero meaning no pain and 10 is very severe pain. Overall, there was good documentation for recording pain. Staff documented the patient’s pain scores on clinical observation charts. Patients we spoke with told us that there was good pain management. One patient we spoke with informed us that their pain had been well managed since their operation, which was two days ago. We looked at the patients drug chart and saw that pain relief was prescribed correctly. However, the drug chart only stated ‘given by’ and the ‘prescribers signature’. There was no space to document the members of staff name and qualification therefore; it was impossible to trace who administered the medication. Another patient we spoke with told us that staff checked on their pain when they were doing their daily observations. Patients we spoke with told us that they felt comfortable in asking for additional pain relief if required. Patients also told us that staff explained who to use their pain medication correctly. Patients also reported that staff would help to reposition patients if required.

The hospital had a dedicated pain team; these services were limited but ward staff we spoke to said it ran really well. This team had two members of staff at the time of the inspection, but was about to lose one member of staff the following week. The team automatically come to a ward every morning to review patients. Ward staff were able to make referrals to the pain team and had the option to contact the anaesthetists if the pain team was not available.

**Patient outcomes**

From September 2016 to August 2017:

- All patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.
- General Surgery patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.
- Trauma & Orthopaedics patients at the trust had a similar to expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at the trust had a higher expected risk of readmission for elective
admissions when compared to the England average.

- All patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- General Surgery patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma & Orthopaedics patients at the trust had a similar to expected risk of readmission for non-elective admissions when compared to the England average.
- Urology patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Elective Admissions – Trust Level

![Graph showing Elective Admissions – Trust Level](image)

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

Non-Elective Admissions – Trust Level

![Graph showing Non-Elective Admissions – Trust Level](image)

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

(Source: HES - Readmissions (September 2016 – August 2017))

From September 2016 to August 2017:

- All patients at Hillingdon Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.
- General Surgery patients at Hillingdon Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.
- Trauma & Orthopaedics patients at Hillingdon Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at Hillingdon Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.

- All patients at Hillingdon Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- General Surgery patients at Hillingdon Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma & Orthopaedics patients at Hillingdon Hospital had a similar to expected risk of readmission for non-elective admissions when compared to the England average.
- Urology patients at Hillingdon Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

**Elective Admissions - Hillingdon Hospital**

![Graph showing elective admissions](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.*

**Non-Elective Admissions - Hillingdon Hospital**

![Graph showing non-elective admissions](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.*

(Source: Hospital Episode Statistics)

In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 6.8% which was within the expected range. The 2015 figure was 5%.

The proportion of patients having surgery on the day of or day after admission was 82.7%, which was worse than the national standard of 85%. The 2015 figure was 80.1%.

The perioperative medical assessment rate was 92.9%, which failed to meet the national standard of 100%. The 2015 figure was 88.4%.

The proportion of patients not developing pressure ulcers was 96.2%, which falls in the middle 50% of trusts. The 2015 figure was 85.6%.

The length of stay was 30.2 days, which falls in the bottom 25% of trusts. The 2015 figure was 25.5 days. Medical staff we spoke to were aware of these figures. Staff stated that patients were coming in with multiple fractures and that there was a high ethnic minority population waiting for care packages that contributed to their length of stay. Staff also stated that there was an ageing population and that there were a higher proportion of patients not receiving surgery due to being on anti-coagulation and an increase in frailty patients, which also contributed to length of stay.

(Source: National Hip Fracture Database 2016)
In the 2016 Bowel Cancer Audit, 92.7% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national average. The 2015 figure was 81.5%.

The risk-adjusted 90-day post-operative mortality rate was 1.4% which was within expected range. The 2015 figure was 8.8%.

The risk-adjusted 2-year post-operative mortality rate was 17.8% which was within expected range. The 2015 figure was 21.8%.

The risk-adjusted 30-day unplanned readmission rate was 3.6% which was within expected range. The 2015 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 53.2% which was within expected range. The 2015 figure was 61.2%.

(Source: National Bowel Cancer Audit)

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 28.4%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2015 figure was 22.8%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 42.2%, higher than the national aggregate of 37.6%.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

In the 2016 National Emergency Laparotomy Audit (NELA), the Hillingdon Hospital achieved a red rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 66 cases.

The Hillingdon Hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 66 cases.

The Hillingdon Hospital achieved an amber rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 38 cases.

The Hillingdon Hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 28 cases.

The risk-adjusted 30-day mortality for the Hillingdon Hospital was within expectations, based on 66 cases.
In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2015/16 performance on groin hernias was worse as the England average.

For varicose veins, performance was worse than the England average.

For hip replacements, performance was about the same as the England average.

For knee replacements, performance was about the same as the England average.

(Source: NHS Digital)

**Competent staff**

Staff we spoke to told us that all new starters were allocated a mentor until they felt competent in the wards. New starters would observe and part take in all clinical aspects including admissions and discharging patients. When nurses felt competent to discharge patients, they were allowed to do so alone. There were no competencies specifically designed for discharging patients, but staff were able to follow a checklist throughout the discharge process. If a nurse was discharging a patient with a condition that they had not seen before, they would call upon another staff member and observe this discharge first.

We asked the ward manager on Jersey ward to show us the competency folder for the agency staff. The manager informed us that agency staff kept their own records on them and that no other copies were kept within the department.
In theatres, the practice development manager had created and developed a new welcome pack for new starters. This included care certificates for competencies. Scrub staff were encouraged to develop and progress into surgical first assistants due to a shortage of junior doctors, via a university course. This meant that the hospital could refrain from using locum doctors to cover surgical lists. In theatres, we saw competencies in paediatric immediate life support training, and immediate life support training. All staff in theatre had personal development reviews (PDR) completed and sign off.

From April 2017 to November 2017, 95% of staff within surgery at Hillingdon Hospital had received an appraisal. The trust did not provide an appraisal target rate. Medical staff had the lowest completion rate of 39%.

<table>
<thead>
<tr>
<th>AC – Surgery</th>
<th>No. staff required (YTD)</th>
<th>No. staff who have received an appraisal (YTD)</th>
<th>Completion rate</th>
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<tbody>
<tr>
<td>NHS infrastructure support</td>
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<td>24</td>
<td>100%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>18</td>
<td>18</td>
<td>100%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>3</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>10</td>
<td>10</td>
<td>100%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>88</td>
<td>85</td>
<td>97%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>109</td>
<td>105</td>
<td>96%</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>110</td>
<td>43</td>
<td>39%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

**Multidisciplinary working**

We saw evidence of multidisciplinary team (MDT) working in patient’s notes. We saw entries from physiotherapists, occupational therapies and speech and language therapists. We observed physiotherapists on the ward with patients; there was a positive rapport with the nurses and the patients. Staff we spoke with reported helpful multidisciplinary working within the wards. The occupational therapists (OT) had an office on the wards and met with the nurses twice a week. Other MDT meetings involved doctors, physiotherapies, discharge teams and social workers, which occurred on a Tuesday and a Friday of every week. The nurse in charge on the wards also attended trauma meetings in theatres every morning. During these meeting consultants, doctors and theatre staff discuss elective and current trauma patients. We observed good multidisciplinary working between preadmission and anaesthetic staff in pre-admission.

There was strong multidisciplinary team working in theatre, this was observed during surgical briefs and surgical operations. We saw positive rapsorts between all theatre staff.

**Seven-day services**

The trauma nurse was available most weekdays but not weekends. This nurse worked alongside consultants, and would flag up trauma patients. The trauma nurse liaised with other hospitals.
regarding spinal patients and organised appointments and transfers for these patients. The trauma nurse would feed back to nurses on the ward and provide support on how to deliver specialist care.

The trust had a formal agreement with another trust for patients requiring interventional radiology out of hours or at the weekend. The two consultants employed by the trust for interventional radiology had an agreement that they would not be off at the same time. The majority of patients for this procedure were inpatients, with a few outpatient surgeries for embolization procedures, only day cases were done at this trust.

The hospital had a dedicated theatre list for emergencies during normal working hours, which was available 24/7. This was known as CEPOD lists. Trauma and orthopaedic medical staff were on call for 24/7 along with a senior house officer (SHO). There was an additional resident medical officer (RMO) on call overnight. The hospital had a 24/7 emergency theatre crew. Consultants always manned trauma lists daily, both upper and lower surgeons were available if specialist surgery was required. Junior doctors reported that surgical patients were reviewed rapidly when referred to other specialities.

The divisional services had limited support out of hours, staff had access to a clinical site practitioner and staff reported that their main focus was on bed management. The hospital provided matron cover from 8am to 5pm Monday to Friday. The critical care outreach team provided support from Monday to Friday 8am to 5pm. The temporary staffing bureau operated Monday to Friday 8am to 4pm and Saturday 8am to 12 midday; which all limited the support available to teams out of hours.

Clinical pharmacists provided a ward based service Monday to Friday and the dispensary was open on Saturday and Sunday mornings.

The Ortho-geriatrics team saw trauma patients with hip fractures over the age of 65.

Health promotion
We saw that the wards had posters on flu, wellbeing, stroke, smoking cessation and healthy eating.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
We looked at patients’ notes and found that consent was documented correctly. However, we did find the white copy of the consent form, meant for the patient to take away, filed in patient notes. We looked at consent in another set of notes and found that the patient’s relative had countersigned the consent form on behalf of the patient. This was done correctly and the correct sections of the form were completed. All consent forms we reviewed indicated that the risks of surgery was explained and discussed with the patient.

Patients over the age of 75 that presented with a neck of femur fracture underwent a 4AT test. This is an assessment test for delirium and cognitive impairment. No other patient underwent this test. We asked a doctor why this was but they were unsure of the reason. Staff we spoke with told us that the 4AT test was not carried out systematically. An audit was conducted, and results showed that the assessment was not being carried out as it should and delirium in patients was not being detected. However, no actions were put to mitigate this. We looked at patients notes that had a 4AT test completed which indicated delirium and cognitive impairment. We saw evidence of
psychiatry referral two days after the test was completed, and regular entries and updates by the psychiatrist in the patient’s records.

We found a resource folder on Jersey ward, which held information on safeguarding, female genital mutilation, prevent, modern slavery, mental capacity act and deprivation of liberty safeguards (DoLS). When we asked senior staff about the contents of the folder, those staff members replied that the folder had ‘just appeared last night’ and that they had never seen that folder before.

We observed that particular patients had DoLs in place and that there were many references to DoLs inside the patient’s notes. However, when we asked to look at the DoLs form for these patients they could not be located. We spoke to two nurses who could not locate a completed DoLs form; they also did not know what this form looked like. We then asked the nurse in charge to find a completed DoLs form; the nurse found three patients with DoLs forms but only one of these forms were signed. This meant that patients had a DoL’s in place without the completion of the correct paperwork and without the necessary assessment.

We observed a dementia notice board on the wall near the entrance of the ward. There was information on how to obtain a carers passport. This meant a relative or a carer of a patient with dementia could access the ward at any time with their carers passport. Therefore, during protected meal times carers or relatives who wished to assist with feeding were able to do so. Nursing staff used a dementia pain score from and completed the ‘this is me’ document for patients. We observed the patients name and preferred name clearly written above patients beds. Staff we spoke with told us that the keypad at the door entrance was to stop anyone leaving the ward without having asked to do so. On Kennedy ward, all patients with confusion or dementia were kept in the same four-bedded bay. There was one HCA caring for this bay along with another four-bedded bay and three side rooms. This staff member told us that they felt guilty for spending the majority of the time with the patients with dementia, and that was not enough time spent looking after the other patients.

We observed falls care plans updated along with bed rails assessments completed. However, we observed that one patient had a bed rails assessment completed which stated that it was not recommended, but the bed rails were in use.

Staff we spoke with told us that there were no dementia champions within the hospitals and that they had not received any dementia training. Staff in theatres was able to explain the mental capacity act and showed a good understanding of DoL’s.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Is the service caring?

Compassionate care

We observed nurses and HCA’s measuring a patient’s blood sugar level and blood pressure on both wards. We saw that staff were able to gain a verbal consent with the patient before the procedure. We saw that staff wore gloves where appropriate and washed their hands or used the hand sanitizer gel after the procedure. We observed the staff interactions with the patient were friendly and polite, and we saw that staff feedback the results of the procedure. Staff generally
appeared caring, polite and compassionate. We observed an HCA explain to a patient in a polite manner why they had not been able to give them a wash in the morning, and inform the patient of when they were going to do this. We saw a patient being assisted to sit in a more comfortable position with the use of pillows.

We observed an HCA demonstrating high levels of care for dementia patients. This staff member answered repeated questions with kindness and constantly attempted to cover up a patient who kept removing their covers.

A patient we spoke with in Jersey ward told us that they had been looked after well. However, the patient had not been able to shave whilst at the hospital and as a result, the patient grew a beard that they did not want. The patient also reported that they felt ‘a mess’ as they had not been able to cut their hair. The patient had been at the hospital for more than a month and was not sure how they would cope at home. The ward had arranged a carer’s team to visit the patient a day after their discharge and had arranged a district nurse too.

We observed patient centred care and patient dignity preserved as much as possible during surgeries. This was achieved using paper underwear and reducing the length of time a patient went without a gown. We also saw dignified checking of patient wound sites as staff closed curtains before exposing the patient.

We observed an HCA compromising a patient’s dignity on Jersey ward. A patient who required a walking frame needed to use the toilet. The HCA walked the patient to the toilet whilst holding an incontinence pad in their hand, which was clearly visible. The toilet was not big enough for the patient the nurse and the walking frame. Therefore, the HCA changed the patient’s incontinence pad with the toilet door opened. The HCA did not wear an apron, but did wear gloves, which were disposed of, in a domestic waste bin. The toilet seat was left soiled after use.

The Friends and Family Test response rate for surgery at The Hillingdon Hospital was 23%, which was lower than the England average of 29% from December 2016 to November 2017.

A breakdown of response rate by site can be viewed below.

**Friends and family test response rate at The Hillingdon Hospitals NHS Foundation Trust, by site**
Emotional support
We saw staff providing explanations of procedures and reassurance to patients who required this.

We spoke to patients on the ward who told us that they were not sure if there was any counselling services available to them after their surgery.

Understanding and involvement of patients and those close to them
Patient relatives we spoke with were happy with the care given to their relative. One relative said that staff were friendly and caring and ‘can’t do enough for you’. Relatives were happy with the communication and information given to them from staff.

We observed a nurse explaining to a patient of why they needed to have their blood ketones tested.

In theatres, we observed anaesthetics staff completing the WHO five steps to safer surgery checklist whilst the patient was awake, involving the patient in their treatment.

Is the service responsive?

Service delivery to meet the needs of local people
The hospital was aware of the ageing population in the local boroughs that surrounded the hospital and improved their services for neck of femur fractures. They did this by increasing their trauma services from half day to all day trauma operations.
The trust set up hot clinics run by associated specialists to prevent hospital admissions. This initiative ran for seven days a week. These clinics were staffed by specific nurse Monday- Friday and were covered by SAU nurses at the weekend.

From October 2016 to September 2017, the average length of stay for all elective patients at the trust was 3.5 days, which is similar compared to the England average of 3.3 days.
For trauma & orthopaedics elective patients at the trust was 4.5 days, which is higher compared to the England average of 3.3 days.
For general surgery elective patients at the trust was 3.2 days, which is similar compared to the England average of 3.3 days.
For urology elective patients at the trust was 1.8 days, which is similar compared to the England average of 2.0 days.

Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

The average length of stay for all non-elective patients at the trust was 6.0 days, which is higher compared to the England average of 5.0 days.
The average length of stay for general surgery non-elective patients at the trust was 3.9 days, which is the same compared to the England average of 3.9 days.
The average length of stay for trauma & orthopaedics non-elective patients at the trust was 11.2 days, which is higher compared to the England average of 8.9 days.
The average length of stay for urology non-elective patients at the trust was 6.7 days, which is higher compared to the England average of 2.9 days.

Non-Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

From October 2016 to September 2017, the average length of stay for all elective patients at Hillingdon Hospital was 3.9 days, which is higher compared to the England average of 3.3 days.
The average length of stay for general surgery elective patients at Hillingdon Hospital was 3.6 days, which is higher compared to the England average of 3.3 days.
The average length of stay for trauma & orthopaedics elective patients at Hillingdon Hospital was 6.1 days, which is higher compared to the England average of 3.3 days. The average length of stay for urology elective patients at Hillingdon Hospital was 1.8 days, which is similar compared to the England average of 2.0 days.

Elective Average Length of Stay - Hillingdon Hospital

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<td>Urology</td>
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Note: Top three specialties for specific trust based on count of activity.

The average length of stay for all non-elective patients at Hillingdon Hospital was 6.0 days, which is higher compared to the England average of 5.0 days. The average length of stay for general surgery non-elective patients at Hillingdon Hospital was 3.9 days, which is the same compared to the England average of 3.9 days. The average length of stay for trauma & orthopaedics non-elective patients at Hillingdon Hospital was 11.2 days, which is higher compared to the England average of 8.9 days. The average length of stay for urology non-elective patients at Hillingdon Hospital was 6.7 days, which is higher compared to the England average of 2.9 days.

Non-Elective Average Length of Stay - Hillingdon Hospital

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Note: Top three specialties for specific trust based on count of activity.

(Source: Hospital Episode Statistics)

Meeting people’s individual needs

The hospital provided a range of information leaflets including support groups. However, we did not see any information printed in any other language. Staff we spoke with in the female day unit told us that they would ask reception staff for assistance in gaining a translator. Admin staff we spoke with could not verify this and staff we spoke with told us that they had had no training in this area and would need to call a ward clerk for assistance. We did observe hearing loops for patients/visitors heard of hearing and we saw brail on a visitor door for those patients/visitors with impaired vision. This was sporadic and not placed throughout the surgical division.
We spoke to a chaplaincy volunteer and told us that there was a chaplain available 24 hours a day. We spoke to two patient relatives who told us that they were allowed to take their relative to the prayer room within the hospital. They were not aware of an Imam that visited the patients within the hospital but felt comfortable in asking staff if they wanted an Imam to visit their relative. We were not aware of arrangements for other faiths.

We observed patient’s dietary needs and fluid restrictions clearly displayed above patients beds. We saw an Asian diet menu, which was written in English, as menus were not available in any other language. However, there was a book with photographs of all the meals that were available to patients. Patients were able to view this and point out meal choices if English was not their first language. We saw that beaker style drinking cups that prevented spills; these were available to patients in the surgical wards.

Female day surgery bays did not have call bells, emergency buttons or piped oxygen. Inpatients could stay in this unit for up to seven days. The day surgery ward was therefore being used inappropriately as an in-patient ward. There were also no washing facility available for patients on this unit.

We observed patient warming blankets in date and available for patients during surgery. These blankets help maintain a patients core body temperature during surgeries that were half an hour or longer.

Tests for dementia were only performed on patients over 75 that presented with a neck of femur fracture. No other patients qualified for this test.

**Access and flow**

The preoperative assessment clinic form did not indicate in the “going home” section that day case patients need to go home by car not by public transport, have access to a phone and a responsible adult for 24 hours post discharge as per National Guidelines.

In the pre-assessment area, the patients waiting area could not be used due to maintenance work. This work had been ongoing for six months. Therefore, patients were waiting in chairs lined along the corridor of the entrance to the pre-assessment area. Staff worked Monday to Friday 7.30am to 5pm. Clinics only ran on a Saturday when staff wanted to come in. Patients were given 30 minutes slots for day cases and an hour slot of inpatient cases.

The female day care unit, originally designed for day cases only, was housing inpatients. There was no operation policy in place for this and some patients stayed for up to seven days on this unit. This meant that some patient operations were cancelled, as there was no beds available pre and post-surgery. When the female day care unit opened as an inpatient ward staff were expected to work a 1 hour and 15 minutes extra. This was because day shift finished at 8pm and the night shift started at 9.15pm. Some staff often worked until 9.30pm despite escalating this to the site practitioner, the matron and higher management. Staff was then required to start their next shift at 7.15am the next day, and often came in earlier.

We observed the day room in Kennedy ward used to house a patient overnight. The room had been set up to have one bed and a bedside locker. There was no bedside table and no curtains,
staff had set up pull around screens for privacy. The patient had access to a nurse call bell, an emergency bell, piped oxygen and the male-shared bathroom. There was a notice board in the day room, which held patient information such as complaints and support groups. These were no longer accessible to other patients as the day room was being used as a side room.

Medical outliers were housed in surgical wards. The nurse in charge was expected to attend every doctor ward round. However, due to medical outliers, there was often more than one ward round occurring at the same time; consequently, the nurse in charge was unable to attend all ward rounds. The nurse in charge therefore read patient notes in order to keep updated. Nurses we spoke to in SAU stated that medical outliers were appropriately low risk. Nurses commented that they did not have an issue in contacting the parent teams for reviews.

Surgical wards were a long way away from theatres therefore patients took a long time to arrive at theatres. We observed a theatre porter waiting for 15 minutes in Kennedy ward before he could take the patient down to theatre. The theatre porter reported that they would often have long waits before bringing a patient down to theatres. The delays occurred because there was no nursing staff available to escort the patient down to theatre with the porter and to check the patient out of the ward.

There were only seven recovery beds in the recovery unit. For the last few weeks, two of the beds were taken up with patients from intensive care. This resulted in cancellations of patient surgeries. The recovery unit was also being used to house patients overnight. On the last day of our inspection, the recovery unit had two patients from accident and emergency and two patients from intensive care. This left only three bed spaces to recover patients after surgery. This meant that male and female patients were next to each other in recovery. We were also informed that paediatrics patients had been moved back into the anaesthetic room after surgery, to recover. The recovery unit had no washing facilities or changing rooms and patients were eating food whilst other patients were recovering. The hospital did not comply with the national guidance issued by the associations of anaesthetists of Great Britain and Ireland, in relation to the recovery room facility. This guidance recommends that the ratio of beds to operating theatres should not be less than two.

Many discharges occurred out of hours but wards had access to an out of hour’s team to ensure patient safety. Staff in recovery were not trained to discharge patients, for example providing patients with ‘to take away’ medications which caused delays.

The hospital also set up ambulatory care to allow patients to recover at home and return to the hospital for a follow up appointment. This helped to release hospital beds. Trauma patients were on standby at home to save beds.
In Kennedy ward, we were informed of two inpatients that had lengthy extended stays in the ward.

From December 2016 to November 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery ranged between 52-62%, which was worse than the England average. In November 2017 56% of this group of patients were treated within 18 weeks versus the England average of 69%.
A breakdown of referral to treatment rates for surgery by specialty is below. Of these, one specialty was above the England average and four specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT</td>
<td>100%</td>
<td>64%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>58%</td>
<td>73%</td>
</tr>
<tr>
<td>Urology</td>
<td>63%</td>
<td>77%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>45%</td>
<td>61%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0%</td>
<td>70%</td>
</tr>
</tbody>
</table>

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

In Q3 2015/16, this trust cancelled 36 surgeries. Of the 36 cancellations 6% weren't treated within 28 days.
In Q1 2017/18, this trust cancelled 36 surgeries. Of the 36 cancellations 3% weren't treated within 28 days.
In Q2 2017/18, this trust cancelled 44 surgeries. Of the 44 cancellations 0% weren't treated within 28 days.

Over the two years, the percentage of cancelled operations at the trust showed downward trend, and was generally lower than the England average. Theatre staff we spoke to reported that breast operations and operation for patients with cancer were prioritised. Staff we spoke with reported that cancellations often occurred the day before an operation due to bed pressures.

Percentage of patients whose operation was cancelled and were not treated within 28 days - The Hillingdon Hospitals NHS Foundation Trust
Over the two years, the percentage of cancelled operations at the trust showed an upward trend and was generally lower than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations. 

(Source: NHS England)

Learning from complaints and concerns
From November 2016 to November 2017, there were 149 complaints about surgical care at The Hillingdon Hospital. The trust took an average of 51 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed in 30 days. The process in which to make a complaint was not clearly sign posted, and complaint leaflets were stored in a room, which was occupied by a patient. However, the hospital did have information on complaints displayed on their website, this included escalation details for the Parliamentary and Health Service Ombudsman.

The most prevalent subject matters are:
All aspects of clinical treatment (surgical group) – 67 (45% of complaints)
Appointments, delay/cancellation (out-patient) – 20 (13% of complaints)
Attitude of staff – 14 (9% of complaints)

(Source: Routine Provider Information Request (RPIR) P61 – Complaints)

We spoke to two patients and one relative; who were all very complimentary about the care and staff. One patient said, “they do the best with what they have”

Is the service well-led?

Leadership
The trust was split into four clinical divisions; surgery fell under the clinical division of surgery and anaesthetics. Each clinical division had a Divisional Director (DD). The DD was the head of each clinical division and held the responsibility for the division’s service delivery, budget and strategy. The assistant director of nursing (ADN) and the assistance director of operations reported to the DD. There were six managers under the ADN and four Associate Clinical Directors.
Staff in the divisional management team that we spoke with raised concerns around capacity challenges out of hours. Executive staff told us that issues that arose out of hours were not always addressed with appropriately. Problems were dealt with in the moment with little forward planning. Staff on the wards reported that when issues were raised to management staff in the division they were shut down. Staff reported that management would often say that there was a bed crisis across the country, that there were no other alternatives and that staff needed to pull together. Staff on the wards expressed to executive staff all the problems that they were facing and how stressful wards can be. However, staff reported that executive staff was limited and have their hands tied. Staff we spoke with told us that the executive team occasionally visited the wards. At time of our inspection wards consisted of a shared matron, two ward managers, registered nurses, HCA’s and agency staff. Theatres had a theatre manager, no matron, a band seven nurse per theatre, operating department practitioners and band five vacancies. Staff reported that staff retention was low and that this was linked to poor relationships with management. Staff we spoke with said that managers needed to listen to staff more often and discuss issues, this was not happening at the time of the inspection. Staff reported poor recognition from managers.

Staff we spoke with in pre-admission said the lack of band seven staff was ‘felt’ and that they had not seen the director of nursing for two and a half years. Staff reported that this affected their training compliance, as they did not have their training requests signed off in time. Staff further reported that they were often left without senior management and “no one in charge”. The nurse in charge on Kennedy ward was not aware of who the executive staff of the division were. The nurse in charge said that the staff did not know who to turn to or who to ask for things that were needed. Furthermore, the nurse in charge said that issues lied with staff wanting to have information more readily accessible, instead of always having to seek things out. This included training.

Staff in theatre reported a positive relationship with their manager and described their manager as good.

Vision and strategy
The hospital vision was ‘to be an outstanding provider of healthcare through leading health and academic partnership, transforming services to provide best care where needed’. Their purpose was ‘to provide high quality, safe and compassionate care improving the health and wellbeing for the people that we serve’. The hospital had a set of values called CARES which stood for; communication, attitude, responsibility, equity and safety. We saw CARES posted dotted around the surgical division in wards and in theatres.

All staff wore lanyards around their necks, which embossed the CARES values. We spoke to staff regarding the trusts vision and they were unable to answer questions on this vision. When we prompted staff on the CARES values staff were able to recall the acronym but not what each letter stood for. This meant that the values were not embedded in staff culture and that the values were a separate body to day-to-day working.

Culture
Overall, we found an inclusive and constructive working culture within the surgery service. Staff we spoke with felt that the hospital was a good place to work. We met many staff members that had been working at this hospital for over 10 years, and were proud to do so and many staff knew each other well. Nurses and doctors reported approachable and supportive colleagues and
described the working environment as made up of a positive staff group. The culture in the hospital was open friendly and welcoming. Staff were talking openly about their challenges and their experiences at the hospital. Agency staff we spoke to on the wards said that staff often stayed late to finish their paper work but the time taken to do this work was like doing charity work, working out of good will and not claiming for over time. Staff reported that they would often make the most of what they have.

Staff in pre-admission had a less positive outlook and would answer many of our questions by saying that it was not in their job description. Staff reported that the pre-assessment unit lacked senior staffed and they were not well supported.

**Governance**

Theatres held daily staff meetings that cascaded new information to the team; including trust agendas, infection control and improving everyday practice. This was known as a theatre huddle, which was newly developed. This meeting was attended by managers, surgeons and anaesthetics. The meeting discussed bed availability, staff, and ward availability. Theatres won ‘team of the year’ for setting up this morning huddle.

Theatres conducted monthly audits, which included sharp audits, joint audits and tap filter audits. Results of the monthly audits were discussed at monthly meetings and dates were set in advance to conduct the next audit.

In the theatres staff room we saw learning from recent incidents displayed on notice boards.

There were monthly governance meetings that took place within the surgical division. We looked at the minutes from the last four meetings. We saw that the divisional director, clinical speciality leads and senior service managers were all in attendance of these meetings. Items discussed at these meetings included incidents, the risk register, patient quality and patient experiences.

Preadmission staff could not recall their latest incident and did not have strong governance structures in place. Nor did they know if there was anything new and upcoming in the clinic, we were informed that no audits were produced in preadmission.

The WHO five steps to safer surgery audit form was developed in partnership during monthly governance meetings with nursing staff, surgeons, and medical staffing. This was not yet in use.

**Management of risk, issues and performance**

The surgery risk register fed into the divisional risk register. Items on the risk register were given a RAG (red for high, amber for moderate or green for low) status dependent upon the level of risk. All risks recorded on the register were documented as active, with the last reviewed date and the next review date documented per risk. This meant that risks from 2012 were still on the risk register and still in an active status, such as overcrowding in waiting areas. All risks identified on the risk register had mitigating controls put in place however, an additional column identified gaps and drawbacks of mitigating each risk. Not all risks identified during the inspection were recorded on the risk register. This included the preoperative fasting audits and the lack of resuscitation trolley on certain days in recovery.
We requested data on risk assessments for the female day care unit, Kennedy ward and SAU. Individual risk assessments had not been performed per ward. However, the female day care unit had risks identified relating to the lack of call bell, lack of piped oxygen, lack of washing facilities and nutrition, which was documented in the risk register. The risk register recognised that the additional beds in the female day unit, the male day unit, the Kennedy day room, Jersey ward and SAU might compromise patient’s privacy and dignity. But had failed to recognise these risks within theatres.

The compliance to the WHO five steps to safer surgery checklist was documented on the risk register. The hospital recognised that a lack of auditing was a risk and had a direct correlation to recent serious incidents that had occurred. The risk register identified a failure in the escalation of deteriorating patients, but had failed to recognise a gap in sepsis training needs and knowledge.

The risk register recognised that the critical care outreach team was not available 24/7. The register documented that cover was going to increase to 8am-8pm in October 2017 however; we found that this was still not the case during our inspection.

We requested standard operating procedures (SOP) for length of stay oversight and management of stranded patients within the hospital. SOPs is a set of step by step instructions complied by the trust to help workers carry out complex routine tasks. The hospital did not provide any SOPs and instead provided an escalation flow chart for stranded patients. SOPs aim to achieve efficiency, quality output and uniformity of performance, while reducing miscommunication and failure to comply with polices. In preadmission staff we spoke with said that there were no phones and printers inside consulting rooms, and in order to make a call staff were required to leave patients by themselves in consulting rooms.

Information management

We did not see signs on how to access information for raising a complaint displayed clearly on the ward. Staff we spoke with was not able to locate and access information that they required easily to provide safe and effective care. This included information on sepsis and deprivation of liberty. The intranet was available to all staff and contained links to current policies and procedures. All staff we spoke with knew how to access the intranet and the information contained within. We found the intranet user friendly and we were able to search the intranet for policies with ease.

Ward staff did not have quick access to their emails; there were a limited number of computers within the wards, which was often occupied by other medical staff. We did not see ward staff checking their emails throughout the inspection. This was due to a lack of computers and a lack of time.

Engagement

Staff we spoke with reported that meetings were meant to be once per month but that they were not happening that much. However, if information was required staff were able to find the ward manager at handovers.

A variety of staff award schemes was presented at the trust. These included a staff reward and recognition scheme comprising of monthly staff awards presented by executive directors and a staff to staff rewards scheme. The trust also had annual staff awards. We spoke to a domestic member of staff who was recognised for their patient care and won an ‘award in compassionate care’ last year.
We observed notice boards encouraging and sharing good news and success and a student corner. We also saw a 'bring us your good ideas' poster for staff. We saw staff rotas and reference to CARES values on staff boards in staff rooms.
Critical Care

Facts and data about this service

The critical care at the Hillingdon Hospital provides nine beds including, five level three intensive treatment unit (ITU) beds and four level two high dependency unit (HDU) beds. The trust states that they have the necessary equipment to offer a degree of flexibility to these figures and are thus able to provide up to nine ITU beds should the need arise. The trust endorses the Department of Health guidelines that recognise the importance of maintaining a minimum of a one is to one nurse to patient ratio to support the delivery of intensive care and a nurse to patient ratio of one is to two for high dependency care.

The department provides care for both pre-booked (post-operative patients requiring high dependency care) and emergency admissions from the wards and emergency department.

In April 2016 to March 2017, there were 432 admissions and 358 discharges from the critical care unit.

The unit adopts a multidisciplinary approach to care led by intensivists and anaesthetists, supported by nurses, physiotherapists, pharmacists and dietitians in providing holistic care. The unit is part of the North West London critical care network. The trust is also supported by a critical care outreach team of nurses that work with the clinical teams across the hospital in managing patients on the basis of referral. Alternatively, patients can also be flagged as requiring support by triggering the national early warning score system.

(Source: Routine Provider Information Request (RPIR) – Context acute)

Is the service safe?

Mandatory Training

There was a statutory and mandatory training programme, which all staff completed annually and attendance was monitored. Sessions were a mixture of e-learning programmes and face-to-face training, with formal attendance monitored.

Staff told us they were given time to complete their mandatory training and received reminders when training was due.

All designated nurses in charge in ITU had completed advanced life support training and were available to support the resuscitation team if required.

A breakdown of compliance for mandatory courses in March 2018 for all staff (nurses, additional clinical services and administrative staff) in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained (YTD)</th>
<th>Number eligible (YTD)</th>
<th>Completion (%) YTD</th>
<th>Target Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>80%</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>90%</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
All mandatory modules met the trust target. We requested data from the trust about doctors’ training figures but this was not provided.

(Source: Additional data request DR 67)

All staff had completed dementia awareness training as part of the mandatory training requirement of the trust. The trust did not provide any compliance data for doctors. We requested data from the trust about doctors’ training figures but this was not provided.

Staff did not receive any specific training on potential needs of people with learning disability and autism.

Safeguarding

Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk, or had been exposed to abuse. There was a clear and effective process to ensure that potential safeguarding concerns were escalated. Nursing staff were able to give an example of the last safeguarding referral made on the unit. Junior staff told us there was always ready access to a senior member of staff for a second opinion on any potential safeguarding issues.

An up-to-date safeguarding adult’s policy that reflected national guidance was available to staff on the intranet. Staff knew how to escalate concerns to the wider trust safeguarding team.

Staff completed safeguarding training every three years as part of the mandatory training programme. We saw individual staff training records, which showed staff had completed the training. Any staff with outstanding training had a date booked to attend a training session. The trust set targets of between 80-90% for completion of safeguarding training, dependent on module.

A breakdown of compliance for safeguarding courses in March 2018 for all staff (nurses, additional clinical services and administrative staff) in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained (YTD)</th>
<th>Number eligible (YTD)</th>
<th>Completion (%) YTD</th>
<th>Target Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>80%</td>
<td>49</td>
<td>52</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>90%</td>
<td>47</td>
<td>52</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>90%</td>
<td>45</td>
<td>51</td>
<td>88%</td>
<td>No</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>141</td>
<td>155</td>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>
One of the three safeguarding training modules failed to meet the trust target. The trust did not provide any compliance data for doctors.

(Source: Additional data request DR69)

Staff showed in-depth understanding of female genital mutilation (FGM). All staff we spoke with were aware of the doctors’ holding powers and nurses’ holding powers under the Mental Health Act.

There was an ‘adult and young people restraint policy’ in place for extra observation or supervision and restraint. We saw a physical restraint checklist that was used by staff to assess patients at risk of suicide or self-harm. The unit used safety mittens, which are soft mittens, that cover the hands and prevent patients from pulling out any lines or tubes that were being used to give them medication, fluids or nutrition. Staff told us that if mittens needed to be used, this would be signed off by a consultant, the nursing shift leader and the named nurse responsible for care.

Cleanliness, infection control and hygiene

The provider had an Infection Prevention and Control (IPC) policy, which was up to date. There was an IPC link nurse and all staff were provided with annual training in IPC.

Most areas that we inspected were visibly clean, including most equipment. At the time of last inspection, we found dust on the curtain tracks and on high surfaces. At this inspection, we found that there was dust on a portable defibrillator and some high surfaces. On the second day of inspection, we noted a bloodstain on blood gas testing machine, which was not cleaned until the next day when we informed the nurse in charge. We saw that cleaning schedules and checklists were in place and completed on a daily basis. All curtains were clean and stain free, but one curtain did not have a date of when it was last changed.

Due to space limitations, the unit had not increased the number of isolation rooms since the previous inspection. There was still one isolation room. This was an accepted risk which had been added to the unit risk register. During this inspection, two patients with an infectious disease were in the unit and required isolation. We observed that staff worked closely with the clinical microbiologist and the infection control team in the management and prioritisation of these patients waiting to be admitted to the isolation room.

Staff adhered to the bare below elbow (BBE) dress code and we observed staff cleaning their hands regularly. We observed staff using personal protective equipment (PPE) such as gloves and aprons appropriately where indicated.

There were dispensers with hand sanitising gel situated in appropriate places around the unit. Hand washbasins were equipped with soap, disposable towels and sanitiser. Guidance for effective hand washing was displayed at the basins. Hand hygiene audit results showed 100% compliance in April 2017 to February 2018, except in December 2017 when compliance dropped to 88%. We observed staff handwashing practice during the inspection. In a morning ward round, we observed that not all staff washed their hands in line with ‘Five Moments for Hand Hygiene’ guidance as they moved from one bedside to another. On another occasion, we observed a member of staff washing their hands hastily and not in line with local or national policy.

Between January 2017 and December 2017, the unit did not report any cases of MRSA. MRSA is a bacterium that can be present on the skin and can cause serious infection. We saw evidence in recent patient records that MRSA risk assessments were completed and that MRSA screening was carried out where appropriate. In December 2017, there was one incident of MSSA (meticillin susceptible staphylococcus aureus - a type of bacterium that can live on the skin and
develop into an infection, or even blood poisoning) and *Clostridium difficile* (a bacterium that can infect the bowel and cause diarrhoea, most commonly affecting people who have been recently treated with antibiotics).

Intensive Care National Audit and Research Centre (ICNARC) data for the unit showed no concerns in relation to hospital-acquired infections, such as MRSA or *Clostridium difficile*. Performance in these areas was slightly better than other comparable units.

We observed safe systems for managing waste and clinical specimens during the course of inspection. Staff used sharps appropriately; most of the containers were dated and signed when full to ensure timely disposal, not overfilled and temporarily closed when not in use.

**Environment and equipment**

There was increased risk of cross infection, as at the time of our inspection; the ITU environment was not compliant with recommended building (HBN04-02) standards for critical care units and National Institute for Health and Care Excellence (NICE) Quality Standards for infection control. This was an accepted risk on unit’s risk register. Accordingly, there were several control measures in place and the unit was looking into the use of ceiling pendants (suspension systems to keep equipment off the ground) to improve the environment around the bed spaces, however there was no specific completion date for this.

There was no negative air pressure ventilation on the unit or within the isolation room. At the last inspection, there was limited mechanical ventilation in critical care and the unit was non-compliant with heating and ventilation for health sector building (HTM 03-01) standards. Since our last inspection, the unit had made some progress in achieving compliance. The first phase of installation of a new ventilation plant to serve ITU had taken place. However, the new plant could not run at sufficient speed until the completion of the second phase of internal ductwork reconfiguration, which was scheduled for summer 2018. Following this, the system would reach full HTM-03 performance compliance. At the time of inspection, the unit was unable to provide optimal care for patients requiring isolation facilities such as positive and negative air pressure management.

Disposable equipment was easily available, in date and appropriately stored. There were two resuscitation trolleys in the ITU; we checked both trolleys, including emergency drugs, airway equipment, defibrillators and oxygen masks. Nursing staff documented equipment checks twice daily and checked the expiry dates of medicines on a weekly basis. This demonstrated that equipment was safe and fit for use, with appropriate actions recorded to report any missing or expired items.

The unit had a difficult airway/ intubation trolley, located in a marked area in the middle of the clinical area. We reviewed the logbook for November, December 2017 and January 2018, and found that there were inconsistencies in the daily checks as defined per trust policy. We found no signatures or ticks to indicate staff had checked the trolley for most of the dates in this period. On the dates the trolley had been documented as checked, staff did not necessarily tick all of the boxes on the available checklist. Several entries also showed that trolley was not always kept sealed.

The equipment on the unit was maintained and serviced as required. We met with the biomedical engineering manager who told us that there were no issues with servicing any equipment in ITU at the time of inspection. Each piece of equipment was given a unique number and held on an asset register. A computer log of all equipment showed when servicing or planned maintenance was due. The equipment team ensured equipment was serviced regularly and helped to source any additional clinical equipment required.
The training log in the unit showed that all nursing staff had been trained in the use of each piece of equipment at least once. However, the log showed that competencies for many staff for some key pieces of equipment were highlighted as red, had not been rechecked, and were now overdue. This included haemo-filtration devices, nasal cannula high flow devices, suction units, syringe drivers, transfer monitor and transfer ventilator.

Staff were required to self-assess their equipment competencies and keep a log of this. We reviewed training records of 12 nurses and only three contained up-to-date records of equipment competency checks.

Assessing and responding to patient risk

Assessment tools were used for assessing and responding to patients’ risks. For example, the venous thromboembolism tool (VTE), nutritional screening tool (NST) and Safer Skin Care (SSSKIN) were all in use. This information was utilised to manage and promote safe patient care. Patients’ consciousness levels were recorded using the Glasgow Coma Scale (GCS) and Richmond Agitation-Sedation Scale (RASS) was used to monitor agitation in sedated patients. We saw evidence of this in all nine records we reviewed.

Staff used the Confusion Assessment Method for the Intensive Care Unit (CAM ICU) to assess whether patients were delirious while on the unit. This practice was in line with current best practice guidance from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. We saw a quick reference flow chart that was designed to guide clinicians in monitoring pain relief, sedation and delirium for patients on the unit.

As per trust policy, when a patient was transferred to the ward a national early warning system (NEWS) chart was started with a minimum of two sets of observations to enable ward staff to see trends.

The hospital had a critical care outreach team (CCOT) who assessed deteriorating patients elsewhere in the hospital. There was a separate resuscitation team for the trust. The outreach team told us that there was still high demand for their service and they were not able to meet all the requests made for their input. Their time was therefore prioritised in accordance with level of risk. For example, requests for assistance from emergency department were dealt later on, as staff with the emergency department were usually sufficiently skilled to deal with the majority of issues.

All members of the CCOT were trained in advanced life support (ALS) or Intermediate life support (ILS) and were contactable by emergency bleeps.

There was no sepsis policy in place at the time of our inspection. Staff did not use any sepsis screening tools or sepsis care bundles. The critical care outreach team informed us that sepsis was part of the deteriorating patient guideline. All staff we spoke with were unable to locate any guidance on sepsis and were unaware that sepsis was covered within the deteriorating patient guideline. They were not aware of any sepsis bundles and had not received any specific training on identifying or managing sepsis. Despite this, all consultants, senior nurses and members of the outreach team we spoke with were confident that all clinical staff within ITU were skilled in identifying the signs of sepsis and managing it. This was due to increased levels of observation in the unit and staff access to specialist critical care training. However, these staff were concerned that sepsis was not identified early enough across other departments in the trust. They told us that some admissions to critical care were due to delayed recognition of sepsis in the wards. According to ICNARC data covering April 2016 to March 2017, the level of high-risk sepsis admission stood at 13.8%, which was within expected range but higher than other similar units (9.9%). The figure for April 2017 to September 2017 was worse at 20%, which was still within the expected range but much higher compared to other similar units (8.2%). The outreach team told us that they were aware that much work was required around sepsis within the trust. When we
raised this during inspection, the CCOT informed that sepsis management would be added to the divisional risk register.

There was no unit specific admission policy in place. The unit was part of the North West London Critical Care Network (NWLCNN) and followed the network admission policy. The critical care service was consultant led. The majority of the patients were admitted via a consultant. The unit did accept registrar to registrar admission, in which case the ITU registrar would discuss the case with the on-call consultant over the phone to agree a care plan.

Admission to Intensive Care should occur within four hours of making the decision to admit. Evidence submitted showed that during January 2017 to December 2017, there were no delayed admissions to ITU.

Staff informed us that there would be debrief if they had been involved in an aggressive or violent incident.

Nurse staffing

There was an adequate skill mix among the nursing staff. The nurse manager was supported by three senior sisters. The other staff were band six and band five nurses. At the time of last inspection, there was no health care assistant in the unit. Since the last inspection, the unit had employed one whole time equivalent (WTE) health care assistant (HCA). All staff welcomed the role of HCA within the unit.

Senior nursing staff used an acuity tool to determine safe staffing levels across critical care. The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units states that all ventilated patients (level three) are required to have a registered nurse to patient ratio of a minimum of one is to one to deliver direct care, and for level two patients a ratio of one is to two. We reviewed patient allocation records and staffing levels during our inspection. We looked at the record of 15 shifts, and found that five shifts were understaffed and did not comply with the required staffing levels.

The Hillingdon Hospital have reported their staffing numbers below for the period April 2017 to November 2017. Nursing staff reached 88% of planned capacity as at November 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Planned Staff</th>
<th>Number in post as at November 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Hillingdon Hospital</td>
<td>48.6</td>
<td>42.5</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From December 2016 to November 2017, the trust reported a vacancy rate of 9% in critical care for qualified nursing staff at Hillingdon Hospital, compared to the trust's overall vacancy target rate of 8%. During inspection, the unit manager informed that in February 2018 the vacancy rate increased to 16%.

Several nursing staff we spoke with told us that they felt the unit was understaffed, especially in recent weeks, when winter pressure arrangements required them to help care for patients in the theatre recovery. All relatives we spoke with said that they could see that staff were very busy. One relative told us that on one day prior to inspection, there was only one nurse for every three patients. This meant a wait of two hours for nursing assistance to change clothing when a patient was incontinent. The unit manager informed us that it has been very difficult to recruit into these
posts, there has been an international recruitment drive, and they had visited the Philippines and India to recruit more nurses.

From December 2016 to November 2017, the trust reported a turnover rate of 7% in critical care for qualified nursing at Hillingdon Hospital, compared to the trust target of 13%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From December 2016 to November 2017, the trust reported a sickness rate of 3% in critical care for qualified nursing staff at Hillingdon Hospital, compared to the trust target of 3%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Critical care had 606 shifts filled by bank and agency staff, which was the eighth highest core service uptake of bank and agency staff within the trust.

The trust did not provide accurate data and therefore we were unable to calculate both the total number of shifts covered by bank and agency and the number of shifts left unfilled. It was therefore unclear if the unit met the ICU core standard of not utilising more than 20% of registered nurses from bank or agency on any one shift. There was induction for any new staff, including agency workers and a buddy was assigned for the shift.

There was a designated supernumerary nurse in charge for every shift in line with the Standards for Intensive Care Services published by the Joint Standards Committee of the Faculty of Intensive Care Medicine and the Intensive Care Society (2013). During our inspection, we observed that the supernumerary nurse was covering a staff break. Staff informed us that due to increased bed pressures recently, there had been many occasions when the supernumerary nurse would cover the short staffed/unfilled shifts. Evidence submitted to us showed that there were six shifts between December 2017 to February 2018, that involved the nurse in charge not being supernumerary for some part of that shift. This was due to either staff sickness or admission of a seventh level three patients and in circumstances where the shift was not being filled by agency or bank staff.

There was a high level of nursing staff with a post-registration award in critical care nursing. The Core Standards for Intensive Care Units recommended a minimum of 50% of nursing staff should have this qualification. At the time of our visit, 69% of the nursing staff had their post-registration award.

A handover took place at the beginning of each shift. During the handover, staffing and patient levels were discussed and it was confirmed that staff to patient ratio met Royal College of Nursing (RCN) guidelines. Staff demonstrated a good knowledge of each patient’s needs, including of their mental capacity and social needs. There was a clear focus on safety and patient comfort. The nursing handover we observed was detailed but did not incorporate any safety briefing about any incidents or complaints that staff needed to be aware of.

The critical care outreach team (CCOT) (providing support for deteriorating patients elsewhere in the hospital) saw as many patients as possible and followed up on patients discharged from the unit onto wards. The outreach team was funded for 3.8 WTE and had 3.67 WTE staff in post at the time of inspection. This included 0.67 WTE staff on maternity leave. Since last inspection, the team had recruited but there were still not enough outreach nurses to provide full cover to patients in the hospital overnight and there were no agreed plans in place to increase the provision of the service to 24-hour cover. This had been on the trust risk register since the last inspection. The CCOT submitted a business case to expand the team to meet the demand but
there had been little progress and support from senior leadership team.

A critical care pharmacist supported the ITU and attended the unit daily. The physiotherapy team provided respiratory management and rehabilitation care and visited the ward daily.

**Medical staffing**

Eight consultants led medical care on the unit. Three consultants had intensivist backgrounds and the remaining five were anaesthetists.

At the time of last inspection, we identified some gaps in consultant cover, as there was no separate on-call rota for the unit. The on-call consultant cover extended across the whole hospital, with no provision for working solely in the ITU. There was now a dedicated on-call rota for the unit. Consultants were allocated to cover the critical care unit in weekly blocks and did not have additional responsibilities within the hospital while responsible for the critical care unit. This type of rota system ensured continuity of care and was in line with best practice guidance. Out of hours, a registrar was always available in the unit and the consultant on call was able to attend within 30 minutes.

We requested data from the trust about medical staff (doctors and consultants) vacancy rates but this was not provided.

We requested data from the trust about medical staff (doctors and consultants) turnover rates but this was not provided.

We requested data from the trust about medical staff (doctors and consultants) sickness rates but this was not provided.

The trust did not provide accurate data for the total number of shifts overall and therefore we are unable to calculate the total number of shifts covered by bank and locum and the number of shifts left unfilled.

There was one consultant on duty in the general critical care unit for the nine beds, which was in line with guidelines for the provision of intensive care services and within the range of the recommended ratio of one consultant for eight to 15 beds. The consultants were fully committed to the critical care unit when they were on duty and did not have other responsibilities within the hospital to attend to.

There was a medical workbook for new and returning intensive therapy unit (ITU) doctors. This included subjects such as advanced ventilator strategies, common problems within the ITU and airway management. There was also an orientation workbook covering the location of specific pieces of documentation and equipment and the geography of the hospital site.

The ITU was consultant-led. There were three ward rounds each weekday, led by the consultant on duty. There was input to the early morning ward rounds from unit-based staff, including both trainee doctors and nursing staff. The midday round was led by the consultant and attended by the pharmacist, microbiologist, trainee doctors and nursing staff. Other allied healthcare professionals were asked to attend as and when required. This included dietitians, speech and language therapists and specialist physicians. The consultant led the evening and weekend ward rounds with trainee doctors and nursing staff.
Records

The unit used paper records. There was no plan to upgrade to using more secure, efficient electronic records. We found paper patient records to be detailed, with evidence of personalised care plans and multidisciplinary input that adhered to guidance from the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC). Patient records and clinical notes were created and stored securely in line with GMC Confidentiality (2009) guidance.

All records relating to the patient’s current critical care stay were kept separate from their main patient record. Two separate folders, one containing all nursing notes and another for medical and multidisciplinary team (MDT) notes, were kept at the patient bed space, making all records readily available to the clinical team.

We reviewed nine health records. All records we looked at included details of allergies, a daily treatment plan and evidence of daily consultant reviews. Specialist assessments were conducted and recorded appropriately, including feeding, neurology and respiratory needs. All relevant risk assessments were completed and there were care-plan booklets for different risks. These included a pressure-ulcer risk assessment tool, falls and nutritional assessment. There were clear clinical indications, doses and duration of treatments document in all patient records where an antimicrobial was prescribed.

On discharge from the unit, a discharge summary was incorporated into the in-patient medical records. We saw evidence of clear and comprehensive discharge summaries completed for patients leaving the unit. These included VTE risk assessments and VTE prophylaxis treatment the patient was currently receiving. We saw that a formal handover document was used for people being stepped down from the unit. Patients were provided with rehabilitation booklets whilst on the unit, which each patient would take with them when fully discharged.

We looked at nine patient records and we observed how these were reviewed and updated during ward rounds. Staff noted both communication with relatives and changes in a patient’s behaviour or outlook.

Doctors and nurses were able to view patient’s telemetry (electronic monitoring of heart rate and blood oxygen saturation level) at the nurse’s station and staff escalated concerns as appropriate.

Staff demonstrated a good understanding of the need for confidentiality and we observed them using electronic password protection systems effectively to access blood test and imaging results.

There were 78 DNACPR orders (Do Not Attempt Cardiopulmonary Resuscitation) in ITU from February 2017 to February 2018. The resuscitation team conducted snapshot monthly audits to ensure compliance with the DNACPR policy. During December 2017 to March 2018, the resuscitation team audited four DNACPR orders in ITU, all sections were correctly completed and included discussion with family and MDT and signed by a consultant.

Staff informed us that they would seek input from the mental health liaison team for risk assessment of a patient’s mental health, where required. We saw evidence that the mental health liaison team reviewed patients within an hour of referral when required.

Medicines

Medicines were stored safely and available for patients when they needed them, including controlled drugs (CDs).
There was one full-time pharmacist dedicated to critical care, who attended the morning ward rounds Monday through to Friday. Weekend and out-of-hours pharmacy support was available via the on-call pharmacist. There was good clinical input by the pharmacy team, providing advice to staff and patients, and making clinical interventions with medicines to improve patient safety.

We reviewed nine paper-based prescription charts and saw they were fully completed, including details of any missed doses. Allergies were clearly documented and antibiotics were prescribed as per guidelines.

We observed nursing staff administering medicines following correct procedures, including CDs being checked by two members of staff and patient identification being confirmed prior to administration. CDs were stored in a locked cupboard, which the senior sister (nurse in charge) held keys for. Documentation showed the stock of CDs was checked once per day. A spot check of the register confirmed documented levels of CDs were correct.

The CD audit highlighted that unwanted CDs were not being returned to pharmacy in a timely manner. At the time of inspection, we found unwanted CDs that had been in the CD cupboard for two weeks. This was highlighted to staff and the medicines were returned to pharmacy on the following day. The chief pharmacist said that he would usually expect unwanted CDs to be returned to pharmacy within one week.

At the last inspection, we found that the temperature check of the medical refrigerator in the clinical room was not always done consistently or documented. There was no clear protocol as to who was responsible for these checks. There were now effective documented systems in place for fridge temperature checks.

The microbiologist attended the daily ward rounds and antibiotics were administered as per local microbiology protocols.

In the ITU, oxygen was not prescribed on the patient prescription chart. The trust policy on the prescribing and administration of oxygen in adults (which was overdue for review from March 2016) stated that a prescription should be written for all patients that required oxygen. The chief pharmacist was aware that the policy needed reviewing. The risk of not prescribing oxygen was being escalated, via the governance committee, to be included on the divisional risk registers.

**Incidents**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2016 to November 2017, the trust reported no incidents classified as never events for critical care.

*(Source: Strategic Executive Information System (STEIS))*

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in critical care, which met the reporting criteria set by NHS England from December 2016 to November 2017. This was a medical device related pressure ulcer meeting SI criteria.

*(Source: Strategic Executive Information System (STEIS))*
All serious incidents (SIs) were investigated and we saw examples of root cause analysis (RCA) completed as part of the investigation. Lessons learned from SIs were shared across teams. We saw evidence of learning in the unit from the last SI and all staff were aware of the most recent SI and actions taken as a result.

The ITU reported 115 incidents between February 2017 and January 2018. All of these incidents resulted in ‘no harm’ or ‘low harm’ and no incident resulted in ‘moderate’ or ‘severe’ harm. Out of 115 incidents, most were related to clinical treatment (61), followed by medication related incidents (23) and then hospital acquired pressure ulcers (nine).

Staff across the department were aware of how to report and record safety incidents and near misses. All staff we spoke with were familiar with the electronic reporting system and how to navigate this. Staff that we spoke with said they were encouraged to report incidents. They were able to give examples of when they had used the system to report appropriate incidents. Junior doctors and nursing staff showed us how to report incidents on the electronic incident reporting system.

At the time of the last inspection, we found that incident investigation and learning was not always fed back to staff. Learning from incidents was now discussed and shared in the monthly unit meeting. However, not all staff were able to attend this meeting regularly. We saw that learning from incidents was also now shared via the unit newsletter. However, the majority of staff told us that they did not get feedback on incidents they reported. Staff told us they were not aware of any particular trends in incidents. General feedback from ‘low’ or ‘no’ harm incidents had still not formally and routinely shared. We were therefore not fully assured that there was any wider learning from incidents across all staff and subsequent actions taken to improve care were limited.

Staff at all levels confirmed there was an expectation of openness when care and treatment did not go according to plan. Most staff were aware of their responsibilities with regards to duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

At the time of the last inspection, we identified that mortality and morbidity (M&M) cases were reviewed, with junior doctors presenting those at teaching sessions. However, there were no formalised M&M meetings held within the unit and there were no M&M discussions with other directorates. We found that the ITU still did not hold formal M&M meetings at the time of this inspection. The clinical director informed us that this was due to a lack of engagement from the medicine directorate.

The major incident plan was kept on the intranet. Staff we spoke with were aware of the action cards to be used in the event of a major incident and could describe the processes and triggers for escalation. However, we found an out-of-date major incident plan in a folder behind the nurse’s station. The unit manager informed us that staff only used the folder for emergency contact numbers and the current plan was on the intranet.

**Safety Thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm-free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.
Data from the Patient Safety Thermometer showed that the trust reported four new pressure ulcers, one fall with harm and one new catheter urinary tract infection from December 2016 to December 2017.

### Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at The Hillingdon Hospitals NHS Foundation Trust

<table>
<thead>
<tr>
<th>Total Pressure ulcers</th>
<th>(4)</th>
</tr>
</thead>
</table>

(Source: NHS Digital)

At the last inspection, we found that safety thermometer information at ITU level was mostly unavailable. At this inspection, we found that the unit monitored incidents of falls, pressure ulcers, venous thromboembolism (VTE), central venous catheter infections and catheter associated urinary tract infections UTIs and information was displayed in both the staff room and on noticeboards within the unit.

### Is the service effective?

#### Evidence-based care and treatment

All intensive care specific policies and procedures we sampled were up-to-date and referenced current best practice from a combination of national and international guidance. References included National Institute for Health and Care Excellence (NICE), Royal College guidelines and Intensive Care Society recommendations.

Policies and guidelines were accessed by staff via the intranet, although some printed copies were available in folders at the nursing station for quick reference. We found some of these folders contained out-of-date policies. Staff told us the intranet search engine was not user friendly and it was difficult to locate guidance online. The unit manager acknowledged the limitations of the intranet and told us that work was needed to update the physical folders.

At the time of the last inspection, the unit was not contributing data to the Intensive Care National Audit and Research Centre (ICNARC). The unit was now contributing data to ICNARC. There was a dedicated co-ordinator employed to submit data to ICNARC. This meant patient outcomes were benchmarked against similar units nationally.

The urinary catheter audit showed improvement in compliance from 33% in April 2017 to 100% in January 2018. The peripheral intravenous devices showed 100% compliance in May, August and November 2017. However, there was a decline in February 2018 to 88% compliance. Staff were reminded of key aspects of care following relevant audit findings.

From January 2017 to December 2017, the audit of the ventilator care bundle showed compliance ranging from 99% to 100% (except in April 2017 when it dropped to 97%). The audit for the central line bundles (CVC bundles) from January 2017 to December 2017 showed compliance ranging from 91% to 100%. The target for these audits was 100% compliance each month.

Patients assessed to be at risk of VTE were offered VTE prophylaxis in accordance with NICE guidance.
The trust had an organ donation committee and was part of the UK national organ donation programme and followed NICE CG 135 guideline: organ donation for transplantation. There was a clinical lead supported by a specialist nurse for organ donation (SNOD). From April 2017 to September 2017, the trust had achieved a 100% referral rate for potential donors.

All patients received daily physiotherapy as required by the NICE guidance for rehabilitation and intensive care society standards. All patients were screened within 24 hours of admission and their rehabilitation needs were identified. Rehabilitation progress was measured using the evidence-based Chelsea Critical Care Physical Assessment Tool (CPAx), so patient progress could be monitored.

**Nutrition and hydration**

Patients’ nutrition and hydration needs were assessed on a daily basis by nursing staff and a designated dietitian assigned to the unit reviewed high-risk patients and those receiving enteral feeding on weekdays. We saw evidence of comprehensive assessments from the dietitian in all nine of the records we reviewed, with clear feeding regimes in place.

We observed fluid monitoring recorded in patient records where appropriate. Staff told us it would always be highlighted during handover if a patient was subject to fluid restriction.

The CQC inpatient survey, covering August 2017 to February 2018, showed that all (18) of the patients said that they got enough help from staff to eat their meals.

At weekends, nursing staff were responsible for initiating enteral feeding if required. Staff highlighted the enteral feeding policy on the intranet and explained they would refer to this policy to calculate feed doses. The dietitian had provided training to staff, information and flow-charts for use on weekends when the dietitian was not available.

Patients provided with total parenteral nutrition feeding (TPN) (nutrients supplied through a central line) were supported by a dietitian. Nurses said TPN was not started out of hours, in accordance with hospital policy. Patients were instead stabilised until a dietitian was on duty.

During our inspection visit, staff told us that there was no total parenteral nutrition (TPN) available in the hospital due to supply issues. Staff reported two incidents related to this. We checked with the chief pharmacist, who was not aware of the issue. However, we were later informed that the incidents were not categorised as medicine incidents and hence were not escalated to the pharmacy. Immediate action was taken, with supply of TPN arranged from another ward while the ward waited for stock to be delivered from an external supplier.

**Pain relief**

Pain relief was managed primarily by consultants on the critical care unit, although input from the specialist pain management team was available on request.

The Critical Care Pain Observation Tool (CPOT) was used to assess pain in non-communicating patients. The CPOT includes evaluation of four different behaviours (facial expressions, body movements, muscle tension, and compliance with the ventilator for mechanically ventilated patients or vocalization for non-intubated patients). Each individual behaviour was rated on a scale of zero to two, with a total score ranging from zero to eight. The CPOT assessment was completed in all records we reviewed for patients where this was appropriate.

We requested data from the trust about any pain audit conducted by the unit, but this was not provided.
The CQC inpatient survey covering August 2017 to February 2018, showed that all (18) of the patients said that the hospital staff did everything they could to help their pain.

The GMC recommends the ‘Abbey Pain Scale’ for people living with dementia; however, there was not any specific pain scale in use for people living with dementia.

**Patient outcomes**

The ITU contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide.

For the ITU at Hillingdon Hospital, the risk adjusted hospital mortality ratio was 1.9 in 2016/17, which was within expected range.

(Source: Intensive Care National Audit Research Centre (ICNARC))

For the ITU at Hillingdon Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.12. This was about the same as the England average.

(Source: Intensive Care National Audit Research Centre (ICNARC))

According to ICNARC data covering April 2016 to March 2017, there were zero unplanned readmissions within 48 hours and the unit was performing better than other similar units (1%) in discharges direct to home.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Evidence submitted showed that in February 2018, four patients were ventilated in theatre recovery and outside the critical care unit. Staff were now keeping a record for the critical care minimum data set (CCMDS) of patients ventilated for more than four hours outside of ITU. Each occasion was reported as an incident on the electronic incident reporting system.

For the ITU at Hillingdon Hospital, the average length of stay in 2016/17 was slightly higher than similar units, at an average of 3.7 days compared to an average of 2.6 days elsewhere.

**Competent staff**

Staff were competent and demonstrated a good level of knowledge and understanding of evidence based practice. They were aware of NICE and Royal college guidelines.

From April 2017 to November 2017, 100% of staff within critical care at Hillingdon Hospital had received an appraisal.

A split by staff group can be seen in the chart below:

<table>
<thead>
<tr>
<th>AC - Critical care</th>
<th>No. staff required (YTD)</th>
<th>No. staff who have received an appraisal (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>48</td>
<td>48</td>
<td>100%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
</tbody>
</table>
At the time of the last inspection, the unit did not have a dedicated practice nurse educator. The Core Standards for Intensive Care Units recommended a unit the size of Hillingdon Hospital should have a practice educator, who dedicated two-thirds of their time to this role. We found no improvement in regards to this provision, despite this risk being present on the unit risk register since 2015. One senior sister had a fifth (0.2 WTE) of their time allocated for the practice nurse educator role.

The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units recommends 50% of critical care nurses should be in possession of a post-registration award in critical care nursing. The unit met this, with 69% of staff currently holding this qualification.

Allocated link nurses were in place for a number of key areas within critical care, such as pressure ulcer prevention and infection control. This allocation meant nurses on the units could seek guidance from their colleagues around specific issues.

Since the last inspection, the unit had implemented the ‘National Competencies Framework for Critical Care Nurses’. All new starters used the ‘step one: competencies framework’. We saw evidence of training records of two new starters, which were comprehensively completed.

All new medical staff underwent a comprehensive induction programme using an induction booklet. Junior doctors told us they felt well-supported and had access to training. There was protected time allocated for teaching. All the junior doctors we spoke with confirmed that they had an allocated educational supervisor. Scheduled teaching for trainees took place every Wednesday morning for two hours. The trainees we spoke with told us both these teaching sessions and additional teaching during ward rounds gave them confidence and equipped them to carry out their role on the unit.

All trainee doctors were trained in Advance life support (ALS) and five of the nine consultants were ALS training providers.

**Multidisciplinary working**

Doctors worked collaboratively with nursing and physiotherapy staff to plan and implement ventilator-weaning programmes (used when patients’ reliability on breathing machines is reducing and they are able to do more breathing on their own).

We observed a nursing handover of care during our visit. The handover was given by the nurse in charge to all the nurses coming onto the next shift. It discussed each patient in depth. A handover sheet was used to record any key information. Infection control issues and safeguarding concerns for any patient currently on the unit were also discussed. The handover demonstrated good leadership, with each member of staff given clear responsibilities appropriate to their role. However, there was no briefing on incidents or sharing of learning or action points from incidents.

The nursing handover was followed by a detailed bedside handover between the individual named nursing staff. These bedside handovers were structured and holistic, covering areas such as physiological and emotional wellbeing of the patients and their family members.

There was a further medical ward round in the morning attended by the consultant, junior doctors and nursing staff. A further multidisciplinary ward round was held at midday, attended by the microbiologist, consultant, trainee doctors, pharmacist and nursing staff. The evening handover with medical and nursing staff was held at 5pm.
Senior sister informed us that a weekly MDT meeting took place to discuss treatment and rehabilitation plans for long-stay patients. Medical and nursing staff and the wider MDT (physiotherapist, pharmacist and dietitian) usually attended this meeting. Staff told us these meetings were beneficial in planning holistic care, as well as the longer-term requirements of individual patients following discharge from critical care.

There was a dedicated physiotherapist team on the unit, led by a senior respiratory physiotherapist. Therapists and nursing staff worked collaboratively to implement rehabilitation plans for each patient. We saw nursing staff and therapists working together to complete patient care tasks and plan rehabilitation during the course of our inspection.

There was no dedicated critical care occupational therapy team. Staff told us the physiotherapists would usually make a referral to occupational therapy (OT) if needed. The occupational therapy department usually responded to referrals within 48 hours.

The critical care outreach team (CCOT) provided clinical cover for patients triggering escalation thresholds according to NEWS, and other clinical emergencies. For example, patients experiencing cardiac arrest, as well as other medical emergencies and the review of all ITU step-down patients. The team also provided teaching in relation to the deteriorating patient, tracheostomy and non-invasive ventilation. They were also involved in the trust emergency simulation education and advance life support training. When the outreach team were not available, the clinical site practitioners were responsible for responding to deteriorating patients, among their other responsibilities.

**Seven-day services**

A consultant was available 24 hours a day, seven days a week. Out of hours, the consultant was available to attend the unit within 30 minutes.

A dietitian was available for five days per week. There was no on-call cover out of hours.

The physiotherapy service was available seven days a week.

Pharmacy services were available from Monday to Friday between 9am and 5:30pm. There was an on-call pharmacist for out-of-hours support.

Imaging services were available from Monday to Friday. Out-of-hours cover was available via an on-call system.

The critical care outreach team (CCOT) provided clinical cover seven days per week. The team were available generally from 8am to 8pm, although some shifts were 8am to 4pm if staff were not available.

**Health promotion**

The physiotherapy team had a comprehensive booklet they used for patients receiving rehabilitation. The booklet had information related to smoking, sleeping, emotional changes and sources of support available following discharge from ITU. The booklet also included links to various external charities and organisations that patients may find useful. For example, patients were signposted to Diabetes UK, and the British heart foundation.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**
Staff adhered to systems in place to provide care and treatment with appropriate consent. Our review of three consent forms found that in all three cases, consent to treatment had been obtained and documented wherever possible prior to treatment and whenever a patient’s condition changed.

We observed staff seeking consent from patients throughout the critical care unit, including explaining the rationale behind the procedure they were going to perform. Where consent could not be obtained, for example with an unconscious patient, staff told us care was provided in the patient’s best interests.

There was a sedation policy in place, which was in date. Staff monitored and audited the use of sedation and delirium recording.

Staff had received training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) as part of mandatory training. Within the unit, 88.9% of nursing staff had attended training specific to MCA and DoLS.

Staff had access to best practice guidance and local mental capacity policies on the unit. Most of the staff we spoke with were able to explain DoLS and how this could impact a patient within the unit. A DoLS checklist was in place for patients requiring mittens for short periods. For patients requiring mittens for longer periods, staff made a DoLS application to the local authority.

Staff completed Mental Capacity Assessments for people who did not have capacity to consent. Staff held best interest conversations with family members or independent advocates where appropriate. Staff also routinely re-assessed capacity whenever a person’s condition improved, in line with the guidance of the Mental Capacity Act (2005).

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**Is the service caring?**

**Compassionate care**

Interactions between staff and patients were positive across the unit. Staff had a caring, compassionate and sensitive manner. Nurses and doctors introduced themselves to patients. We observed staff speaking to patients and their relatives in a caring manner and reassured patients and answered questions about their care. They made sure that patients and their relatives were informed about their daily care plan.

We observed staff ensured patients’ privacy and dignity was maintained and curtains were drawn around bed bays when providing personal care. In the CQC inpatient survey, 18 responses were received spanning August 2017 to February 2018. All of these patients said that they were given enough privacy when discussing their condition and treatment. All patients told us they were always treated with respect and dignity during their stay in the hospital.

We spoke with ten relatives and all the feedback from patients and their relatives was positive. One relative told us, “Nurses and doctors are doing their best”. Another relative said that care provided by nursing and medical staff was “Fantastic” and caring and dignity was “top priority in ITU”.

We noted many ‘thank you’ cards and letters received from patients praising the care they had received throughout critical care. We saw ‘thank you’ card from a patient stating, ‘your kindness, patience and hard work are truly inspirational.’

During a medical handover, we observed that the lead consultant would allocate an individual to speak with the relatives of each patient, depending on the nature and seriousness of the
information to be shared. This showed that consideration was given about how sensitive information would have an impact on relatives.

The unit participated in Friends and Family test. From March 2017 to March 2018, for 48 responses received, 90% of patients said that they were “extremely likely to recommend this hospital to their friends and family”.

**Emotional support**

Staff provided emotional support to patients and told us that patients were able to receive additional support from two psychologists. Spiritual support was available via the chaplaincy service.

Staff were aware of the procedures to follow in the event of a bereavement of a patient. Support was offered from the bereavement team, who would come to the unit if needed. Staff showed us the information booklet for relatives and friends relating to the death of a patient at the hospital.

The inpatient survey from August 2017 to February 2018 showed that all patients (18) who said they wanted to talk to someone about their worries or fears were able to do so. All patients reported they had emotional support from staff, apart from one who said they did not need emotional support.

The unit manager informed us that there were plans to introduce boards at each bedside, in order to put up family pictures of any long-term patient staying in the unit.

Staff told us that patients who had a degree of factual recall of events on ITU were less likely to suffer from long-term psychological difficulties following discharge. For this reason, they used patient diaries in an attempt to help with their factual recall of their experience on the unit. Patient diaries provided a daily record of each day’s events to the patient and were completed by all members of the multi-disciplinary team, families and close friends.

**Understanding and involvement of patients and those close to them**

We spent time speaking with the relative of a patient who had been in the ITU for an extended period. They told us how satisfied they were with the care and treatment their family member had received. They felt treated with kindness and compassion and said, “Care from nursing and medical staff is very good”.

Discussions with patients and families were evident in all of the notes that we examined, including in discharge planning, decisions to transfer to the ward and obtaining consent.

Friends and relatives of patients said they were kept informed and involved with decisions where required. Relatives we spoke with said that they were updated about the patient on each visit to the unit. A few relatives felt they did not get enough opportunities to speak to the doctor as staff were too busy and they felt reluctant to disturb them.

The CQC inpatient survey covering August 2017 to February 2018 showed that all of the patients (18) were involved in decisions about their care and treatment as much as they wanted to be.

Patients told us staff always kept them informed of the treatment plans and staff explained any tests they were due to have. During the ward round, we observed the medical team interacting with the patients who were awake and explaining their treatment. We observed staff interacting with patients and involving them in decisions. For example, we saw that a consultant discussed
further treatment plans with a patient and they both agreed a joint plan regarding the need for ongoing dialysis.

Staff did not have access to communication aids to help patients become partners in their care and treatment. For example, there were no easy read materials available. We did not see any boards with family pictures or cards by any patient’s bed space. This technique can be used to provide emotional support to patient in an unfamiliar environment. The unit manager informed us that there were plans to have bedside boards for patients, but there was no indication when this would be in place.

We noticed that call bells were not always within easy reach of patients who were conscious. We observed one patient tapping at the bed rail to gain a nurse’s attention, as they did not have the call bell within reach.

Is the service responsive?

Service delivery to meet the needs of the local people

As identified at the last inspection, the unit did not meet the requirement for modern critical care facilities as recommended by the Care Standards for Intensive Care Units. Senior staff were aware of the challenges. They informed us that improvements were limited by the existing building and unless the unit was moved to a different location, there was no other option to expand.

At the time of the last inspection, the trust executive team said that there were plans to expand the ITU. During this inspection, the trust executive team gave us a presentation that there will be a newly built ITU as part of the hospital expansion plan, in collaboration with the neighbouring university. However, finer details of the plan and an anticipated timeframe were not provided. The clinical staff in the unit were not confident this plan would come to fruition and some junior staff were not even aware of the planned expansion.

The unit had made no progress in relation to the facilities for patients and relatives. The visitor’s waiting room was divided into two areas, with a seating area at the front and a small room at the rear with a single sofa bed. There was a water dispenser machine, but no disposable cups were available at the time of our inspection. There were no toilet facilities for relatives nearby without accessing the unit through a locked door. All relatives we spoke with said that the space was small and not suitable at busy times. There was only one patient toilet in the unit and no bath or shower facilities.

There was nowhere for visitors to meet with staff in privacy beyond the visitor’s waiting room. The clinical leads informed us that they were aware of the physical challenges of the unit and tried to use the available space effectively. We observed a consultant using one of the staff offices to discuss the care of a patient with relatives in privacy.

The CCOT followed up on patients discharged from the unit onto wards. However, the unit did not provide any ITU follow-up clinics once the patients were discharged from the hospital.

The unit had access to a Regional Home Ventilation and weaning unit. The lead consultant told us that there was a three month wait for the service but this was a national picture.
Meeting people’s individual needs

Staff introduced themselves and explained their role to patients throughout the critical care unit. Patients and relatives told us this was needed because it could be difficult to differentiate between different grades of staff, as all staff wore the same colour theatre scrub uniforms.

The unit was sensitive to patients’ and their relatives’ needs. There were set times for visiting hours to allow patients to rest and for staff to undertake ward rounds and observations. We observed that nursing staff would accommodate visitors at other times of the day where appropriate. All relatives we spoke with said that they understood that staff needed time to look after the patient without distraction and they were accordingly respectful of visiting times. However, we found that there was inconsistency about the information available for relatives in relation to visiting times. Information on the hospital website stated visiting hours were 2pm until 8pm. An ITU leaflet on the trust website stated visiting times were between 12:30 pm and 8pm. The leaflet available on the ward had reduced visiting hours stated of 2pm to 7:30 pm. Two relatives of patients reported being confused in regards to correct visiting times.

Staff have not received any specific training in identifying the needs of patients or relatives with learning disability. There was no learning disability lead for the trust but had a service level agreement with another trust for a learning disability specialist nurse to provide staff with learning disability advice. None of the junior staff we spoke with were aware of this.

The unit manager informed us they did not screen patients over 75 years old for dementia, as this would have already been carried out within the emergency department or on the ward. Staff told us that they had not had to care for patients who were living with dementia in recent years. The trust uses dementia passports for patients living with dementia. However, if required the unit was able to carry out these assessments and issue a passport.

Patients who were able to eat and drink were seen to be offered a choice of food and drinks. Drinks were observed to be within patients’ reach when appropriate. The hostess was able to heat up microwavable meals so patients could eat whenever they requested, rather than having set meal times.

There was written information available on the unit for patients and their relatives. This included general information about the unit, and spiritual support information. There was an option for leaflets to be translated into different format and languages.

Translation services were available via telephone or face-to-face. Staff told us the hospital had many staff who spoke other languages and they were able to provide translation, particularly with medical subjects, if they were available at the time. Staff confirmed they would not rely upon interpretation from a child or family member unless there was a serious emergency. The translation service was used once in the last 6 months by ITU for a face to face service for a patient.

Patients had access to a range of foods including: soft options, vegetarian, gluten free, healthy heart options, halal and kosher food.

Staff demonstrated an understanding of the needs of patients beyond their immediate clinical need in critical care. This included contact with specialists regarding a patient’s alcohol withdrawal, for example.

Access and flow

We saw that capacity and flow was one of the key areas of concerns for the unit. The clinical leads and senior nurses told us that existing numbers of level three and level two beds were insufficient to meet demand, resulting in delay in admission to the unit. This was on the unit risk
register and was monitored regularly. The clinical leads informed us that there was pressure to meet the emergency department targets and thus step-down patients from high dependency unit (HDU) were not always prioritised. The unit was able to use the beds within theatre recovery as an overflow. During inspection, we saw three theatre recovery beds were used as level two HDU beds, all three patients were later transferred directly to the ward and were not required to be admitted to the ITU. Staff informed us that there have been few cancelled operations due to shortage of beds in theatre recovery or in ITU. Evidence submitted showed that during September 2017 to February 2018, there were seven cancelled operations due to lack of ITU beds.

From December 2016 to April 2017, The Hillingdon Hospitals NHS Foundation Trust saw adult bed occupancy fluctuate around the England average. However, from May to November 2017, an increase occurred and the trust’s bed occupancy was worse than the England average.

**Adult critical care Bed occupancy rates, The Hillingdon Hospitals NHS Foundation Trust**

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

*(Source: NHS England)*

For the ITU at Hillingdon Hospital, there were 3,285 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 7.6%. This meant that the unit was not in the worst 5% of units nationally. The figure for April 2017 to September 2017 was worse at 11.9%, which was still within the expected range but much higher compared to other similar units (6%).

According to ICNARC data covering April 2016 to March 2017, the percentage of bed days occupied by patients with discharge delayed more than 24 hours was 5%, which was higher compared to other similar units (3.9%). The figure for April 2017 to September 2017 was worse at 8.3%, much higher compared to other similar units (3.7%). We saw evidence of the ITU quality dashboard, which showed that this was mainly due to non-availability of beds in the wards.

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

For the ITU at Hillingdon Hospital, there were 443 admissions, none of which had a non-clinical transfer out of the unit. Compared with other units, this was about the same as the England average.

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

For the ITU at Hillingdon Hospital, based on 292 admissions, 2.7% were non-delayed, out-of-hours discharges to the ward. These are discharges, which took place between 10pm and 6:59am. Compared with other units, this was about the same as the England average.

*(Source: Intensive Care National Audit Research Centre (ICNARC))*
According to ICNARC data covering April 2016 to March 2017, the unit was performing better (8%) than other similar units (6%) in discharges direct to home.

(Source: Intensive Care National Audit Research Centre (ICNARC))

**Learning from complaints and concerns**

Staff told us that, where possible, they would resolve any issues with patients informally, prior to a formal complaint being made. Any concerns raised by patients on the unit would be addressed immediately by a member of staff, or escalated to the sister in charge or unit manager. Formal complaints were handled by the complaints department or the Patient Advice and Liaison Service (PALS).

Relatives we spoke with were aware they could raise any issues with staff on the ward or seek assistance from PALS if needed. There were information leaflets available for patients detailing how to access PALS.

From November 2016 to November 2017, there was one complaint which involved critical care, which the trust took 48 days to investigate and close. This is not in line with their complaints policy, which states the complaints process should be completed within 30 days. Senior staff informed us that the complaint was mainly related to the care received at another ward before the patient was transferred to the ITU.

**Is the service well-led?**

**Leadership**

The ITU sat within the division of surgery and anaesthetics. The divisional team comprised a divisional director, an assistant director of nursing and an assistant director of operations. The unit level leadership was clinically driven and comprised a clinical lead and a unit manager, who both reported to the divisional team.

At a local level, there was clear leadership for both medical and nursing staff. The lead consultant and unit manager worked closely together. They were both visible in the department and junior clinical staff described them as approachable and supportive. It was clear that the senior staff, many of whom had been working at the hospital for some time, were supportive of each other.

All staff we spoke with said the divisional and executive team were not visible and rarely visited the unit. The staff told us they felt disjointed from the division and not part of the “bigger picture” within the trust. Some consultants reported that the divisional management team were not always visible and felt there was little support for the critical care unit within the trust. The senior leadership team informed us that they are looking to strengthen links across all clinical areas with their division. Some staff who have worked at the trust for more than 10 years told us that the CEO had visited the unit in the past.

At the time of the last inspection, we found that there was no evidence of strong critical care leadership to challenge or influence the future direction of the service. At this inspection, we found there was still lack of any consensus regarding cohesive future direction of the service.

We reviewed minutes of the trust wide critical care delivery board meeting, which met quarterly to review operational projects and themes around acutely ill patients across the trust.
Vision and strategy

The trust vision was “to be an outstanding provider of healthcare through leading health and academic partnerships, transforming services to provide better care when needed”. This was underpinned by the trust CARES values, which stood for communication, attitude, responsibility, equity and safety.

The trust executive team informed us about the future strategy and direction of critical care, to have a brand new critical care unit, which was being developed in partnership with neighbouring university. Senior staff within the directorate were not confident in this concept and junior staff we spoke with were not aware of this plan and that this was at a conceptual stage and there has not been any consultation on this.

The unit manager informed that a separate draft strategy for the unit (2017-2020) had been developed with input from staff. We saw that the ITU draft strategy was linked with trust CARES values. Senior staff had aspirations to expand the critical care outreach service, improve recruitment and retention and improve patient and family experience. However, the strategy was not being cohesively driven forward or promoted, with the future direction of the service unclear.

Culture

There was positive team spirit across the unit, with each member of staff feeling valued. This meant morale in the department was high. We observed good team working among nurses, the unit manager, senior sisters and clinical leads.

We saw collaborative working between ITU, pharmacy and dietitian teams. Junior doctors and nurses felt supported, with regular supervision. We saw that the medical team worked well together, with consultants being available for junior doctors to discuss patients and to give advice where needed. We noted staff were proud of the team dynamics and their willingness to go the extra mile to deliver care. Staff nurses told us that the culture in the department was one of coherence and mutual support.

All staff we spoke with were passionate about providing empathetic care. Staff told us they enjoyed working in the department and all said everyone got on well. Staff, including the ward hostess and cleaners, worked supportively to meet the needs of patients.

Governance

There was a lack of an effective governance structure driven by the unit leadership team. The unit worked with some degree of isolation from the wider directorate and the board. Although some staff were able to identify individuals who had key governance roles and responsibilities within the unit, none of the junior staff we spoke with could articulate the department governance arrangements and how it fed into the divisional governance structure.

The ITU had monthly unit meetings. We noted from the minutes of these meetings that complaints, incidents and operational issues were discussed. These meetings were only attended by nurses and there were no joint formalised meetings between clinical and nursing teams.

Learning from incidents and complaints themes and wider learning from other clinical areas within the division was not evident in the evidence submitted. All staff we spoke with informed us that they did not receive any feedback from incidents they reported.
As identified at the last inspection, there were no formal morbidity and mortality meetings and learning from any clinical case presentations were not shared with the wider directorate, or fed back to the board through any identifiable governance structure.

The divisional leadership team informed us that there were no formal service level agreements; however, there were local agreements with specialist trusts for tertiary referral for renal and liver treatment.

There were bi monthly joint meetings attended by medical and nursing staff. The divisional team informed us that there were also plans to have regular directorate level governance meetings called critical care forums. Some dates have been agreed for those meetings, but this was at a very early stage and would require time to embed in practice.

**Management of risk, issues and performance**

At the time of the last inspection, we found that audits of certain aspects of safety within the unit were not carried out and there was no audit calendar. During this inspection, we found that there were now regular safety audits related to equipment checks. There was now an agreed joint clinical audit programme with the anaesthetic and theatre department.

The ITU risk register fed into the divisional risk register. The risk register items were given a RAG (Red for high, Amber for moderate or Green for low) status dependent upon levels of risk. All those risks identified and placed on the risk register had mitigating actions documented. Not all risks identified by us during the inspection were reflected on the risk register. For example, the lack of formal governance structure within the unit, the lack of morbidity and mortality meetings and the lack of mandatory sepsis training for staff were not included. In addition to this, many risks identified at the last inspection were still outstanding. We requested minutes of the divisional meetings where these risks were discussed and reviewed, but this was not received.

During this inspection, we found that the unit was now contributing data to the Intensive Care National Audit and Research Centre (ICNARC) database for England, Wales and Northern Ireland. The lead consultant told us they had appointed a clinically qualified member of staff to code this information.

As recommended by the Core Standards, the unit was part of a local critical care network in North West London (NWLCCN). The unit submitted data for the NWLCCN quality measures and the meetings were well attended by members, which included 19 NHS hospitals in the local area, the local ambulance trust, and the local clinical commissioning groups.

**Information management**

Staff we spoke with told us they were able to access the information they needed to provide safe and effective care. There were systems in place to manage and monitor care records.

The intranet was available to all staff and contained links to current guidelines, policies and procedures. All staff we spoke with knew how to access the intranet and the information contained within. However, we found that it was difficult to find clinical guidelines on the intranet. In some areas, staff struggled to locate clinical guidelines quickly as the search engine was not user friendly.

All staff had access to their work email and we were shown that they received organisational information on a regular basis, including clinical updates and changes to policy and procedures.
Engagement

We viewed minutes of unit meetings, where staff were able to raise issues as needed. They felt that their contribution was valued and felt part of the local team. However, the majority of staff we spoke with were not aware of how their work contributed to the wider vision of the trust. They felt isolated and not part of the wider divisional team and the trust as a whole. One member of staff told us that there was limited engagement from the trust. The ‘long service award’ was introduced recently but in general, staff felt they did not get feedback from the leaders at board level of leaders.

The unit manager had introduced a quarterly newsletter called ‘Pippa’s post’ to boost pride and confidence in the unit.

The trust participated in the national staff survey. We saw results of the 2017 survey and an action plan. Few members of staff told us that although the trust takes the results of staff survey seriously, they had not seen any change as a result.

Feedback from patients was obtained from the NHS Friends and Family test and inpatient survey.

The unit received nominations from staff and the public for individual ITU and Team members to receive the trust’s ‘Team of the Year’ Award in 2017.

Learning, continuous improvement and innovation

Since the last inspection, there had been limited improvement in the facilities on the unit for relatives and visitors, particularly for a service where delivering bad news is part of daily life.

Although the risks associated with the physical environment had been added to the trust risk register following our previous inspection, improvements were limited and there were few plans to upgrade or improve the unit in future.

The patient notes were paper based records. There was no plan to upgrade these to more secure, efficient electronic records.

The trust was participating in NHS Improvement’s National Retention Programme and working on four key areas for improvement, including; flexible working, staff engagement, promoting respect in the workplace and career development.
Maternity

Facts and data about this service

The Hillingdon Hospital maternity services deliver care for approximately 5,000 women per year following the earlier than anticipated transition of services from Ealing as part of the “Shaping a Healthier Future”, (SaHF) model of care in North West London. In 2013 there had been 4,076 births, representing a significant increase in the birth rate. From October 2016 to September 2017 there were 4,520 deliveries at the trust.

The trust provides a community midwifery service for women living within the London boroughs of Ealing and Hillingdon. The community midwives undertake the majority of antenatal and postnatal care. Antenatal and postnatal clinics are held at Hillingdon Hospital, Mount Vernon Hospital, The Ealing Hub and in children’s centres. This service includes specialist clinics that covered diabetes, raised BMI, perinatal mental health, haemoglobinopathies (inherited disorders of globin, the protein component of haemoglobin), vaginal birth after caesarean section (VBAC), fetal abnormality screening and safeguarding concerns.

The maternity unit is located within a separate hospital building on the Hillingdon hospital site which houses all the maternity and neonatal services. It has an 11 bedded delivery suite with two theatres, two recovery spaces and maternity triage. The delivery suite has one room with a birthing pool. There is also a four bedded midwifery led unit, for women on the midwifery led pathway. The antenatal ward has 13 beds, including a four bay day assessment unit (DAU). There are 21 postnatal beds, split between level 1 and level 3. The postnatal ward has a six bed transitional care unit which is staffed by neonatal nurses with support from a midwife and midwife support worker (MSW).

The hospital has a level 2 neonatal unit designed and equipped for babies needing extra medical and nursing care. This unit has five intensive, three high dependency and 12 special care cots.

During our inspection, we spoke to 36 members of staff including midwives, maternity support workers, sonographers, consultants, trainee doctors, domestic staff and facilities and estates staff. We interviewed the head of midwifery after the inspection as she was away at the time of our visit. We spoke to 16 women who used maternity services and eight of their partners. We observed how staff were caring for patients and looked at the quality of the environment.

We reviewed 26 sets of medical records and observed a multi-disciplinary team (MDT) handover and observed a clinic at a children’s centre. We reviewed a variety of hospital data including meeting minutes, policies and performance data.

A comparison from the number of births at the trust and the national totals over the last 12 months is shown below. Hillingdon hospital provides a medium sized birth unit.
Number of babies delivered at The Hillingdon Hospitals NHS Foundation Trust – Comparison with other trusts in England

A profile of all deliveries from July 2016 to June 2017 can be viewed below.

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>The Hillingdon Hospitals NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
<td>1,278</td>
<td>28.3%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>736</td>
<td>16.3%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>2,494</td>
<td>55.2%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>14</td>
<td>0.3%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>4,522</td>
<td>100%</td>
</tr>
</tbody>
</table>

¹Includes elective and emergency caesareans  
²Includes forceps and ventouse (vacuum) deliveries  
³Includes breech and normal (non-assisted) deliveries

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

The number of deliveries at the trust has remained steady over the last two years, with numbers fluctuating between a low of 1,102 and a high of 1,174 per quarter. Trends by quarter for the last two years can be seen in the graph below.
Number of deliveries at The Hillingdon Hospitals NHS Foundation Trust by quarter

(Source: HES - Deliveries (October 2016 - September 2017))

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory Training**

All new staff received a trust induction, which included statutory and mandatory training.

Midwives’ mandatory training took place over three days, and included training on the Surviving sepsis care bundle. The practice facilitators oversaw staff training and the training database highlighted to staff when training updates were due. The mandatory training schedule was displayed in the staff room, and staff told us it was easy to access training, and that training updates were not necessarily repeats of the previous update and drew on learning from incidents. Training and was delivered by workshop, e-learning and practical exercises on the unit.

In addition to the mandatory and standard statutory training, all midwives (including community midwives) and doctors were required to attend an additional day’s training in cardiotocography (CTG) interpretation, including using ‘fresh eyes’ to check interpretation with another clinician, and monitoring the fetal heart. Midwife and doctor compliance was 91% at the time of the inspection. Neonatal life support (NLS) training was covered in annual practical obstetric multi professionals training (PROMPT). This is multidisciplinary training which includes the use of the hospital’s new...
simulation centre, using a lifelike model mother to practice obstetric emergencies such as shoulder dystocia, haemorrhage, cord prolapse and uterine inversion.

All midwives and support workers attended a two day one off course on breastfeeding. There was announced and unannounced “skills drills” training to rehearse obstetric emergencies

Mandatory training completion by module for staff

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained (YTD)</th>
<th>Number eligible (YTD)</th>
<th>Completion (%) YTD</th>
<th>Target Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>80%</td>
<td>13</td>
<td>13</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>90%</td>
<td>13</td>
<td>13</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>80%</td>
<td>231</td>
<td>234</td>
<td>99%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>80%</td>
<td>209</td>
<td>217</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>80%</td>
<td>225</td>
<td>234</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>80%</td>
<td>220</td>
<td>234</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>216</td>
<td>234</td>
<td>92%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>90%</td>
<td>204</td>
<td>221</td>
<td>92%</td>
<td>Yes</td>
</tr>
<tr>
<td>Corporate Induction</td>
<td>80%</td>
<td>33</td>
<td>36</td>
<td>92%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>80%</td>
<td>192</td>
<td>221</td>
<td>87%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>80%</td>
<td>202</td>
<td>234</td>
<td>86%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>80%</td>
<td>190</td>
<td>234</td>
<td>81%</td>
<td>Yes</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1948</td>
<td>2125</td>
<td>2125</td>
<td>92%</td>
<td></td>
</tr>
</tbody>
</table>

11 out of 12 mandatory training modules met the trust target. Information governance is the only module that had failed to meet the trust target with 92% completion rate compared to 95%.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

On inspection, midwives, support workers, theatre staff and administrative staff told us their training was up to date. The dashboard at the time of inspection recorded 92% completion which was good.

The 10 midwifery support workers (MSW) were on rotational contracts, rotating every three to six months. They took part in skills and drills training with midwives and had training on topics such as manual handling, supporting breastfeeding, sepsis, safeguarding and tissue viability. There was a scheme to standardise training of midwife support workers across North West London.

Medical staff compliance with mandatory training compliance overall was lower than midwives training, at 86%.

Safeguarding

The trust set targets between 80 to 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April 2017 to November 2017 for all staff at Hillingdon Hospital in maternity is shown below:
Safeguarding training completion by module

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained (YTD)</th>
<th>Number eligible (YTD)</th>
<th>Completion (%) YTD</th>
<th>Target Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (level 4)</td>
<td>90%</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (level 1)</td>
<td>90%</td>
<td>222</td>
<td>234</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (level 2)</td>
<td>90%</td>
<td>209</td>
<td>221</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (level 1)</td>
<td>80%</td>
<td>221</td>
<td>234</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (level 3)</td>
<td>90%</td>
<td>142</td>
<td>164</td>
<td>87%</td>
<td>No</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>795</td>
<td>854</td>
<td>93%</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) –Mandatory and Statutory Training tab)

The overall safeguarding mandatory training completion rate in this period for staff at the trust was 93%. The trust’s target of 80 to 90% completion was met for four out of five safeguarding training modules. The module that failed to meet the target was safeguarding children (level three) with 87% completed compared to a 90% target. This had improved slightly at the time of our inspection to 88.4%. All clinical staff were expected to be trained to level 3 in Safeguarding Children.

For new staff, level 3 safeguarding was delivered as a full day’s face to face training. Updates for the level 3 safeguarding training were delivered thereafter in two hours face to face sessions each year. This had proved more effective in ensuring staff attendance compared to the previous full day training. Staff had access to courses run by the London Safeguarding Children Board (LSCB) on topics such as trafficking women, asylum seeking, domestic violence, child sexual exploitation. Maternity support workers in the community were all trained in level 3 safeguarding. Hillingdon were the first trust to use the Royal College of Midwives FGM video during training and workshops.

Group safeguarding supervision took place with the named nurse for safeguarding who was trained to level 4. Ad hoc supervision was arranged by staff as needed. There was a template for one to one supervision to ensure all aspects were consistently covered.

There were comprehensive systems to keep people safe, which took account of current best practice. Safeguarding was well-managed across the different groups of vulnerable women in Ealing and Hillingdon. Twelve wards in Hillingdon had a higher teenage conception rate compared to the London average. Vulnerable teenagers under sixteen were under the care of the complex social care team and staff contacted the P3 Navigator (a charity and social enterprise supporting 16-24 year olds with problems of housing and other needs), when necessary. There were lead midwives for young people under 16 and 18 although teenagers attended normal antenatal clinics. Over 60% of this age group chose to terminate their pregnancies.

A new complex social needs team, which would be fully operational by 1 April, was led by a Band 8 midwife. The team would caseload all women and young people known to social services and ensure social and mental health needs were effectively met. The team’s work would include home visits. The service would offer 24 hour telephone support to their women which would support women more effectively when they needed it. It would also improve flow from the post-natal ward because such women could be discharged with support at the weekend, rather than waiting for
safeguarding lead input on a Monday. Families with a child protection or children in need plan were followed up for 28 days after birth, in liaison with the health visitor. Although overall Hillingdon was about the England average for child protection cases there was a five-fold variation in child protection cases between the highest and lowest wards. A successful business case had been made for an additional part time support worker to help with the social care needs of children in the borough who were subject to child protection, children in need or looked after children. The Clinical Commissioning Group (CCG) set key performance indicators (KPIs) for the hospital's performance in working with these families during pregnancy which the unit was meeting.

The community midwives ran an assessment clinic for women who did not meet the safeguarding threshold, but where there were some ongoing concerns. These women would be seen at this clinic before birth at 16, 25 and 36 weeks of gestation. There were twice monthly maternity safeguarding meetings with the relevant midwives and the local authority. Staff carried out annual audits in relation to domestic violence, multi-agency working and post-natal care of vulnerable women. Hospital midwives reported good support from the safeguarding team who visited women on the wards and supported staff on any issues. The trust had safeguarding champions who helped staff to develop their confidence in identifying safeguarding concerns, attending case conference and writing safeguarding reports.

**Cleanliness, infection control and hygiene**

At the last inspection there had been trust wide concerns about cleanliness. We did not identify similar concerns at this inspection. The maternity matron was the lead for infection control in maternity and carried out spot checks. Ward managers and the facilities team shared responsibility for oversight of cleaning standards, and waste management, taking action in areas that was falling below standard. There were quarterly managerial walk arounds, separate from the oversight of the facilities team. The infection control score was 88.1%, which was below the trust’s 90% target.

All areas we inspected were visibly clean and tidy, including sluices, linen cupboards and other storage areas. We inspected all areas of the maternity unit including the delivery suite, obstetric theatres, wards and midwife led birth unit. We visited one community location, a children’s centre, where midwives gave antenatal and postnatal care. This was tidy and well maintained.

Infection prevention and control (IPC) audit dashboards had been introduced quarterly. Ninety percent of staff had completed the IPC training.

We saw evidence that domestic staff followed guidance in regard to the required cleaning standards, practices, emptying waste bins and frequency of cleaning. There were cleaners assigned to the unit, and staff could summon cleaners by bleep when needed urgently. We saw cleaning checklists in individual rooms and wards.

All staff we saw complied with ‘bare below the elbows’ to allow effective handwashing. Delivery rooms had dedicated hand hygiene sinks for staff to wash their hands before and after direct patient care. Patients reported that staff washed their hands on the ward and encouraged patients and their partners to wash their hands or use sanitising gel. Audits showed 97.50% compliance with handwashing. However we observed less regular hand hygiene in the maternity day
assessment unit (DAU) and in an antenatal clinic, and noted five instances where doctors and midwives did not use hand sanitisers before and after patient contact. We observed a student midwife wearing nail polish which was inappropriate as chipped polish was an infection risk and not in line with trust policy.

Hand sanitising dispensers were available at most entrances. Signs above some gel dispensers encouraged staff and visitors to use the hand sanitiser to clean their hands. We saw staff use hand sanitiser appropriately. However there was no hand sanitiser at the entrance to the antenatal clinic and we saw no women use the hand sanitiser on the reception counter during a busy period in the clinic. There was no hand sanitiser outside the theatre suite.

Hospital midwives reported good support from the safeguarding team who visited women on the wards and supported staff on any issues. The trust had safeguarding champions who helped staff to develop their confidence in identifying safeguarding concerns, attending case conference and writing safeguarding reports.

Personal protective equipment (PPE) was available to minimise the risk of cross infection. In the delivery suite there were gloves, gowns and masks, and sterile gloves for examinations. We observed that staff used PPE appropriately when needed.

To limit infection during labour and immediately after birth, women were allowed two birth partners in the delivery suite, and they could not swap the partners over. Families were not permitted to take babies to the delivery suite door to show relatives.

The incidence of infection for women was low. The rate of readmission in the past year for puerperal sepsis was 0.8%. In only one month in the past year the rate was 1.9% and rated amber on the maternity dashboard. Twenty other women had been admitted within 42 days for other reasons in the past 10 months.

We saw correct segregation of clinical and non-clinical waste by staff which was in line with HTM 07-01, Control of Substance Hazardous to Health, and the Health and Safety at Work Regulations. We saw that staff had labelled sharps bins and that no sharps bins were overfull. This was important to prevent injury to staff and patients from sharp objects such as needle sticks. Community midwives advised women to have the whooping cough vaccine and the flu jab from their general practitioner (GP).

**Environment and equipment**

The antenatal waiting area was not very large but there were enough seats for everyone during our observation of this area. A white board showed the names of doctor or midwife running clinic and information about any delays. The waiting area was clean and clutter free. There were three ultrasound scanning rooms and a separate waiting area for these women, on the same floor as the antenatal clinic. There were further scanning facilities on level 1. There were two quiet rooms that staff could use for confidential discussions with women on any topic. Community midwives said had the necessary equipment for their roles. They said their equipment was calibrated and serviced through the facilities team.

The maternity unit had 11 delivery rooms which were all ensuite. One delivery suite room at the end of the delivery suite was used for bereavement, and had a sofa bed where a partner could
stay. However, if the unit was busy this room was used for normal deliveries. One room on the delivery suite had a plumbed in birthing pool. The four bed midwife led unit had two rooms for delivery and two postnatal rooms although we were told all rooms could be used for delivery if needed.

There were two obstetric theatres, in line with safe practice. Theatre One was the larger theatre. Theatre Two was small in size, but staff managed this space by storing pre-packaged trolleys outside the theatre. We observed and staff told us this was a creative, use of the space. Both obstetricians and anaesthetists considered the space acceptable. If a third theatre was needed staff would use one of the theatres in the main hospital, which was about 3 minutes away through a covered corridor.

Both theatres had obsolete anaesthetic machines for which parts were no longer obtainable. This was on the risk register. Two new machines had been purchased and one was already in the warehouse awaiting delivery to the unit. Maintenance contracts had been set up from April 2018 for these machines, and the second machine was expected within a month.

Ventilation quality in theatres had been a concern at the last inspection. This was rated high on the risk register. On this inspection we saw that remedial work had been undertaken and validation reports were done every six months. Ventilation filters were changed monthly. The remaining issue (the anaesthetic room ventilation) was remedied in mid-March 2018, which meant this room could now be used for epidurals. In the interim the theatres had been used for epidurals which provided a less relaxed experience for women. It had previously been deemed unsuitable for clinical use. Planned preventative maintenance was now established for the ventilation systems. There was appropriate emergency equipment in the delivery suite including drug boxes for specific emergencies such as sepsis and cardiac arrest. We checked the resuscitation trolley and the neonatal resuscitation trolley on the delivery suite were fully equipped, with drugs in date, and checked daily. Trolleys on wards were also checked daily, signed and dated. All electrical equipment observed had been checked for electrical safety.

At the last inspection we had some concerns about the triage area. On this inspection, triage had been moved to a different floor as part of the reconfiguration of the unit. In the new area, staff had sought to create a more private environment for patients, improving confidentiality, privacy and dignity. Triage was used to screen women for access to the delivery suites, prioritising women according to clinical need.

A midwife and maternity support worker staffed the four day-assessment beds. This was for women who required additional care, monitoring and treatment during their pregnancy and after birth.

The postnatal ward was split into two areas with nine beds and a side room on one floor and a further 21 beds (including six transitional care beds) on another floor. Individual rooms in the wards had a cleaning schedule on the doors and all were marked clean for that day. There were also checklists for room equipment to ensure all necessary equipment was in place and safe to use.

At the last inspection we had concerns about access to the maternity area by the public without staff knowledge and appropriate challenge. On this inspection we saw adequate physical security. Cameras provided closed-circuit television (CCTV) cover of the entrance to check who was
entering. We observed that all fire exits were alarmed. There were buzzers on the doors to all the wards. Staff checked who inspectors were during our inspection of the wards, which indicate that they were alert to strangers on the ward. For women at risk of pre term labour a clinic had been set up to measure cervical length. However, there was not sufficient ward clerk cover so midwives and support workers were regularly interrupted to admit visitors. There was no 24 hour ward clerk cover on the delivery suite, so staff were also interrupted during care to let people in.

We noted the external door of double doors to the main entrance to the maternity unit were broken and did not close, but we saw evidence that repair had been arranged. Equipment maintenance and repair was managed centrally by the facilities team. Midwifery staff told us the security service responded promptly and effectively when they were called.

The neonatal unit was not on the same floor as the delivery suite, but on the floor above. This meant that paediatricians had to use the lift or one flight of stairs to attend the delivery suite in an emergency.

The neonatal unit was a level 2 unit, for babies needing short-term intensive care including help with breathing and possibly tube feeding.

**Assessing and responding to patient risk**

The service assessed risks to women and babies proactively at different stages of the maternity pathway, and in line with national guidance. At the initial booking appointment midwives carried out a detailed holistic risk assessment. For example, they assessed health, maternity history, multiple birth, previous caesarean section, weight and age, risk of venous thromboembolism (blood clots), blood pressure and conditions such as diabetes or high BMI.

Midwives documented on-going risk assessments at subsequent antenatal appointments. The criteria for women birthing in the midwife led unit or wanting a home birth, were in line with national guidance. If women falling outside the criteria wanted to deliver on the maternity led unit, a discussion with the consultant midwife would take place to see how midwives could support their choice. There was a weekly ‘birth options’ clinic.

Women giving birth in the midwife led unit were transferred to the delivery suite if higher risks emerged in labour. For example, if midwives had concerns about fetal heart rate anomalies, failure for labour to progress and meconium in the waters. Meconium is baby’s first stool and its presence in the waters can sometimes be an indicator of fetal distress during labour. Women were transferred by chair as the delivery suite was on a lower floor and transfer took five minutes. They would only transfer in a bed in an emergency such as cord prolapse (when the umbilical cord comes out of the uterus before the baby).

Babies needing a higher level of care could be transferred to the hospital's neonatal unit (NICU), level 2. If babies required level 3 care the hospital had links with two other maternity units, one for babies needing medical care and the other for babies needing surgery.

Community midwives referred women who they identified as high risk for any medical reason to consultant-led clinics. Women with social concerns were flagged on the electronic record-keeping system if they were already known to be in vulnerable circumstances. Hospital notes (known as brown notes at this hospital) contained more detail of risk. Staff had regular meetings with a liaison social worker within social services. A fetal medicine unit supported the women who had complications or abnormalities in their pregnancy. The hospital worked closely with the fetal
medicine unit of another hospital in the network service where they could refer women if a baby required specialist intervention.

In the patient notes we observed that staff recorded risk of documented assessment of risk factors for venous thromboembolism (VTE or blood clots) in early pregnancy and after birth. Skin integrity was checked on relevant women for the risk of pressure sores.

A midwife staffed the dedicated maternity triage (assessing and prioritising) 24 hours a day, seven days a week. Women telephoned the triage unit for advice and if they needed examination staff asked them to come in. Staff recorded telephone calls on a standard template to capture key information, and staff obtained women’s notes. Staff prioritised women according to clinical need:

- **Red** = Review within 15 minutes of arrival
- **Amber** = Review within 90 minutes of arrival
- **Green** = Review within 4 hours of arrival

A midwife rated women both before and after examination and observations. Women meeting the National Institute for Clinical Excellence (NICE) and hospital guidelines for a midwifery led care pathway began labour in the midwifery led unit, although some transferred because they wanted greater pain relief. At the last inspection women complained about waiting times and had delays in receiving pain relief in triage. On this inspection women still had mixed views on triage and whether staff gave them sufficient reassurance.

Staff used the Modified Early Obstetric Warning Score (MEOWS) to monitor women on the delivery suite and wards. MEOWS charts are designed to give a clear visual record to help staff identify deterioration at a glance. Staff knew how to use these, and to escalate concerns to a doctor. In the delivery suite staff also used the visual infusion phlebitis (VIP) score tool for assessment of early signs of phlebitis to prevent inflammation of the vein, and the catheter monitoring charts were kept for relevant patients to minimise infection risks in relevant patients. Staff used a care bundle for the management of reduced fetal movements, which was in line with NICE guidance.

We observed a morning multidisciplinary handover on the delivery suite attended by doctors and midwives. The handovers were used to discuss the women in their care, including any transferred out to other hospitals, the stage of labour, patients ready to be discharged and safety items such as medications that needed to be given and staffing levels. Induction lists were updated at every handover so the delivery suite was always aware of women who would later come down to give birth.

Staff were trained to use Situation, Background, Assessment and Recommendation in reporting incidents or escalating concerns, and this technique was also used in handover. We witnessed good response to an emergency on the delivery suite during inspection.

There was a risk board on every ward to alert staff to any current concerns.

On every shift there was a coordinator who held the bleep and kept watch on areas of heightened activity and flow issues. They used a recognised staffing tool every four hours to assess staffing levels, activity and acuity of women on the unit, and reported at morning and evening handovers, or between these if necessary to inform escalation procedures. Staff used the traffic light system in the Pan London policy to show staffing levels. During working hours staffing could usually be managed by drawing on staff in other areas of maternity. At night, escalation was to the site
practitioner. There was 24 hour advice from the professional midwifery advocates (PMA). There were no regular on call midwives although we were told an on call community midwife could come in, but this was rare.

There was a standard list of red flag issues that might lead to escalation such as delays of over 30 minutes to give pain relief or for assessing a woman in labour or in transferring a woman in established labour to the delivery suite from the midwife led unit, or delays in commencement of obstetric surgery.

There was a daily patient safety huddle within the team including the maternity bleep holder, consultant and labour ward coordinator where complex cases were highlighted.

Safety briefings were held before elective caesarean sections. An audit showed good evidence of compliance with an adapted Five Steps to Safer Surgery World Health Organisation (WHO) checklist, to prevent or avoid serious patient harm in the operating theatre. The audit was comprehensive and provide evidence of compliance of the WHO maternity checklist, and also that the correct proformas and consent forms were completed and that the theatre register had been completed appropriately in line with the Caesarean Section guideline. It identified any areas for improvement and was also used to verify if the maternity unit meets the standards required for Local Safety Standards for Invasive Procedures (LocSSIPS). The compliance was 94% in February 2018 audit. Staff had noted that results were not above 90% compliance in every area, for example staff did not consistently document use of disposable instruments. An action plan was produced and a re-audit planned in six months.

Home birth midwives had agreed a protocol with the ambulance service to communicate an immediate life threatening maternal or paediatric emergency to reduce clinical risk. The labour ward clerks updated the Patient Administration System (PAS) on wards out of hours, but gaps in shifts meant the system was not always kept 100% up to date.

Doctors undertook a daily ward round of all women who were inpatients in the maternity unit.

**Nurse and midwifery staffing**

The Hillingdon Hospital reported their staffing numbers below for the period April 2017 to November 2017. Nursing staff reached 96% of planned capacity as at November 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Planned Staff</th>
<th>Number in post as at November 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Hillingdon Hospital</td>
<td>160.5</td>
<td>153.7</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

At the last inspection, although a business case had been agreed for additional staffing appointments had not been made. On this inspection most shifts were filled with permanent staff.

Midwives worked a range of different shift patterns: early, late and long day. Nine midwives staffed the delivery suite. All staff had the same training and were expected to work flexibly between areas depending on demand. For instance, midwives were taken from the midwife led unit to the delivery suite when needed.  

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The maternity service employed scrub nurses but midwives reported they sometimes had to cover this role. At night, midwives took the role of scrub nurse for emergency caesarean sections.

Nurses were used to care for high risk women out of hours. Two more nurses had been appointed in the week of the inspection (March 2018).

There was a separate home birth team, known as the Halycon Homebirth team which consisted of four experienced midwives. The home birth rate was 1.5%.

From December 2016 to November 2017, the trust reported a vacancy rate of 9% in maternity for qualified nursing staff, which was slightly worse than the trust’s overall vacancy rate of 8%.
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

However on inspection we found the vacancy rate had reduced to just 2%.

There was a rolling recruitment programme to maintain safe staffing levels and in some recent months the team had recruited slightly above the number of vacancies to secure suitable new staff.

We were told there was succession planning to support staff who wanted to develop into new roles.

From December 2016 to November 2017, the trust reported a turnover rate of 9% in maternity for qualified nursing staff, which was better than the trust standard of 13%. This low turnover maintained experience. Staff told us student midwives tended to stay for a few years after qualifying at Hillingdon.
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

At the time of the inspection the sickness rate was 4.5% in maternity for qualified nursing staff, compared to the trust target of 3%.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

From December 2016 to November 2017 maternity had 3,307 shifts filled by bank and agency staff which was the fifth highest core service uptake within the trust.
(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

We were told that bank staff were used where possible. There was one agency member of staff on a night shift during our inspection. Agency spend was about 3% of the pay bill which was lower than many other maternity units.

At October 2017 the trust had a ratio of one midwife to every 29.83 women, which is above the national average of 26.82
(Source: Electronic Staff Records – EST Data Warehouse)

A key focus of the Shaping a Healthier Future programme (SaHF) changes was to improve midwifery staffing across NW London to meet the London Quality Standards’ minimum staffing ratio of one midwife to thirty births (1:30). This ratio was benchmarked with others in the region.
and Hillingdon had achieved this. However the Birthrate plus assessment of the number of
midwives needed in relation to the complexity of the women giving birth in the unit, was 1:27/28.
There was a contingency to increase staffing in working hours by escalating concern to the bleep
holder to prioritise the needs of women in labour. Out of hours concerns were escalated to the
band 7 midwife who was usually supernumerary. The site practitioner would help fill shifts through
authorising use of bank or agency staff. There was no system of on call midwives from bank staff.
In theory community midwives might be called in but staff told us this was rare. Escalation details
were held in the bleep holder's folder, known as the 5763 folder.

Midwives scrubbed for emergency caesarean sections although there were scrub nurses for
elective section. The trust were now recruiting more scrub nurses to work out of hours who would
also support antenatal and postnatal care which would free up midwives for more specialist tasks.
At the last inspection we had concerns about the high caseload of community midwives, of up to
200 women. Community midwives had caseloads of 113 women during this inspection.
Management expect the caseload to reduce to 98 when the new specialist support role for women
with complex needs was fully operational, from 1 April 2018.

Staff levels, planned and actual were displayed in each area, although as midwives worked across
different areas on different floors these were not easy to interpret. No staff only worked nights;
rotation was required by occupational health. Staff levels were as planned during our inspection.
Staff said rotas were issued six weeks in advance. Staff shared time off at Christmas and New
Year.

Medical staffing
Consultant obstetric presence of 120 hour a week was in line with the national recommended
practice. The target within the North West London region was 168 hours cover.
There were 15 consultants, five of whom worked only in obstetrics. Most consultants worked in
both obstetrics and gynaecology (O&G). A resident consultant was on call for four days, Monday
to Thursday inclusive of giving 24 hours on call cover on these days. On Friday there was
consultant cover from 8.00am to 10pm. Weekend cover was six hours a day. The timing was
flexible. There was on call consultant cover for the delivery suite when there was no consultant
present, for example on a weekend evening.

Since the last inspection and the closure of the full maternity service at Ealing hospital, the
services now had two registrars as well as a senior house officer (SHO). This was an improvement
from the last inspection when there was only one registrar.

Day cover for anaesthetics was from a consultant and a registrar from 8 am to 6pm. At night and
out of hours, one anaesthetic registrar covered the labour ward, and two anaesthetic registrars in
the main hospital were available to assist as needed. A consultant anaesthetist was on call from
home at night. A separate anaesthetist from the labour ward team covered elective caesareans in
the mornings.

The vacancy rate for medical staff was 3.8% which was lower than the national average.

The trust did not provide detailed information, but staff told us turnover was low as the unit was a
place doctors liked to work.
The sickness rate for obstetric staff was low at 0.8%.

The maternity dashboard showed no locum use in last year.

In September 2017, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was about the same. There were three trust SHO and five trust registrars.

Staffing skill mix for the 36.2 whole time equivalent staff working in maternity at The Hillingdon Hospitals NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>43%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>0%</td>
<td>8%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>49%</td>
<td>45%</td>
</tr>
<tr>
<td>Junior*</td>
<td>8%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

We looked at 26 sets of records for women at different stages on the maternity pathway, antenatal, in triage, in the delivery suite and on postnatal wards, and the overall quality was good. Notes were legible; entries were signed, dated and timed in line with good practice. Risk assessments were recorded. We noted that if a problem occurred, such as difficulty cannulating a woman then midwives recorded the reason for delay and that an apology had been given, in the woman’s notes.

Women’s health records were stored securely in lockable notes trolleys on the wards to ensure confidentiality. We saw staff locking and unlocking these as needed during our inspection. Trolleys were mainly in the nursing station or office area.

Staff were aware that many women had the same or similar names so took care to check all women’s details including hospital and NHS number to avoid any confusion. Same name stickers were used when babies with identical names were on a ward.

We reviewed a records audit of women’s paper health records, which had identified that staff did not always sign and date corrections, the need to document maternal weight on the drug chart and
that every page must have a patient identifier. Generally the audit scores were high indicating good compliance with record keeping standards. Obstetricians were being trained on the electronic health record documentation system as a doctors’ module had been purchased recently.

Notes during labour indicated clearly who was responsible for care.

**Medicines**

At the last inspection the storage of medicines did not comply with nationally recognised good practice. On this inspection, medicines were stored securely in locked cupboards in locked rooms. There were separate locked cupboards for controlled drugs. We found that the controlled drugs register was up to date, and epidural packs were appropriately stored. Medicines requiring cold storage were stored in dedicated fridges and temperatures were checked and recorded. The fridges were clean. The blood fridge also had a recorded temperature check. A pharmacist covered the maternity and neonatal unit.

We looked at prescription administration charts for 10 women. We found that people’s allergies were documented appropriately, although we saw from the medication safety thermometer report that some allergy records were not dated and signed. The same report recorded that women who were self-medicating were not always prescribed the drugs they were taking and no self-assessment form was completed in accordance with the policy. Staff said that now this issue had been highlighted, staff were taking action to improve compliance.

**Incidents**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Staff were aware of Never events and learning from these was used in training.

*(Source: Strategic Executive Information System (STEIS))*

In accordance with the Serious Incident Framework 2015, the trust reported 12 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from December 2016 to November 2017.

Of these, the most common types of incident reported were:

- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with five (42% of total incidents).
- All other categories with two (17% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with two (17% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother only with one (8% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant) with one (8% of total incidents).
- Screening issues meeting SI criteria with one (8% of total incidents).
Staff told us there was an open reporting culture.

We saw good evidence of learning from serious incidents. Root cause analyses were thorough and of high quality. We reviewed minutes of the monthly multidisciplinary incident review meetings which had systematic recording of actions taking place on serious incidents and instances of duty of candour, and consideration of the outcome of investigations. We saw from minutes of the March 2018 Incident Review meeting that there were five open SIs at the time of the inspection, four of which had passed the CCG deadline. The status of each open incident was reviewed at the meeting and progress was evident on all the incidents.

We saw evidence of action taken in response to incidents such as amending guidelines and introducing specific cases for future training. All medical trainees said learning from serious incidents was widely disseminated and senior trainees were encouraged to assist in writing SI reports which was good practice. Staff were invited to attend learning reviews from incidents. We also saw evidence of opportunities to learn from external safety events and patient safety alerts, through self-assessments against national maternity reports. A communication folder was used as one method of ensuring staff were aware of safety information, for example the folder contained up to date safety alerts such as Safety Alert on the Risk of death and severe harm from the failure to obtain and continue flow from oxygen cylinders (January 2018).

There were triggers for incident reporting. We noted that staff did not report delayed transfer to the delivery suite unless the woman waited over 12 hours. Delays were recorded as a red flag issue for staffing. There was a systematic process to the investigation of incident reports and we saw evidence of action and learning from these. Staff said they usually received feedback on incidents they had reported within 24 hours of the incident being closed.

An incident summary and analysis was reported to the Maternity Strategy Board. As at the previous inspection midwives reported most incidents and very few medical staff reported incidents. Most incidents were clinical, 8% were medication related, and a proportion were related to the environment. On average 100 incidents were reported each month.
Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 introduced the Duty of Candour. This Regulation requires a provider to be open and transparent with a patient or other relevant person when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. Midwives and doctors we spoke with had a good understanding of the duty of candour and the need to apologise to mothers and families when things went wrong. Staff said relevant scenarios were discussed in training. One person who had been involved in contacting a family and then writing to them about duty of candour spoke of good support from management. However, regional benchmarking showed less duty of candour reporting than other maternity units in the region and staff were investigating this.

As at the previous inspection, mortality reviews were held regularly following the trust mortality review process, with paediatric participation if appropriate.

### Safety Thermometer

The Maternity Safety Thermometer is a measurement tool by staff in maternity units to use for recording the prevalence of harms specific to maternity units. It focuses on: perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. The tool allows teams to take a temperature check on harm and records the number of harms associated. Staff used this and results were displayed, and were within national expectations. There were no outliers in the month displayed.

### Is the service effective?

#### Evidence-based care and treatment

Maternity guidelines were developed in line with the recommendations of National Institute for Health and Care Excellence (NICE) and those of the Royal College of Obstetricians and Gynaecologists (RCOG). We reviewed seven guidelines in detail and found all were clearly written, up to date and referenced national guidelines, and signposted sources of additional help. A maternity guideline panel ratified guidelines before publication.

New national guidelines were effectively promoted to staff through training and meetings. For example, we saw a poster about revised Cardiotocography (CTG) guidelines, based on RCOG guidelines in the staffroom.
Instead of having one designated coordinator to coordinate all the antenatal and newborn screening programmes, the role was shared between several specialist midwives who attended the screening meetings held by Public Health England in rotation. Key performance indicators (KPIs) were coordinated by one member of the team and an administrator supported failsafe checking across all screening. There were no immediate issues identified in the Antenatal and Newborn Screening Programme quality review. KPIs were within acceptable thresholds.

The hospital offered women a non-invasive prenatal test to evaluate the risk of certain chromosomal conditions to replace invasive tests which carried a small risk of miscarriage. This was good practice. They had also introduced a non-invasive blood test for women who were Rhesus Negative which picked up fetal blood in the woman’s circulation to determine the need for the woman to have anti-D immunoglobulin injections to ensure the baby did not develop rhesus disease.

Enhanced recovery - an evidence-based approach designed to help people recover more quickly from surgery including caesarean section - was used for women having planned caesareans. This helped more mothers be well enough to go home from hospital the day after surgery.

A number of maternity-related audits had been completed the previous year including women’s health records, electronic health records, post-partum haemorrhage, induction of labour, bladder care and a case based review of placenta accrete. There was an audit plan for 2018 with 17 proposed audits including venous thromboembolism (VTE) in obstetrics, multiple pregnancies, thalassemia in pregnancy and the national failsafe audit, intrapartum monitoring and stillbirth. Audits were related to risks on the risk register in line with good practice.

Opportunities to participate in benchmarking and peer review were actively pursued within the regional network, and through reviewing performance against national maternity reports and recommendations. The unit also took part in research. The hospital had a research midwife and was contributing to several external research projects such as a trial to prevent pre-term birth in twin pregnancy (STOPPIT2), Getting It Right First Time (GIRFT), a programme designed to improve clinical quality and efficiency within the NHS, the National Pregnancy in Diabetes Audit and the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK).

In the 2017 MBRRACE audit their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 4.98. The comparator group was 5.19. The trust had also participated in a study of women with a body mass index over 35 using midwife led birth centres. Staff told us they reported to the Each Baby Counts programme, which are a Royal College of Obstetricians and Gynaecologists (RCOG) national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.

Births on the midwife led unit were audited monthly, including admission, deliveries, transfer and incidents. The transfer rate was 23% which was reasonable as most low risk women started labour here.

**Nutrition and hydration**

Fluid charts were kept for women with catheters. There was water available to women on the wards. Water was available for women in the hospital antenatal and ultrasound clinics. There was also a café with a wider range of drinks.
A light snack, such as a sandwich or toast and a drink was available to women within half an hour of birth.

Improving the rate of breastfeeding was a priority for the service. The trust was aiming, jointly with the local authority for Stage 2 accreditation in the UNICEF baby friendly scheme by September 2018. Most staff had undertaken the education programme to prepare them to care for mothers and families effectively.

Women on the postnatal ward told us they had help with breastfeeding. Breastfeeding rates were high compared to the national average, with an average of 86% initiating breastfeeding. Although new mothers were encouraged to breastfeed, Women were supported to feed their babies however they chose.

**Pain relief**

Women considered methods of pain relief as part of their birth plan and received information about options in the antenatal period.

The epidural rate (national average 30%) was 59.40% for first time mothers and 28.4% in women who already had a child. We were told that epidurals were available to women on the delivery suite within 30 minutes, which was the nationally recommended time. If there was a delay this was reported as a ‘red flag’ incident. Anaesthetists provided 24 hour cover for epidurals for pain relief.

The delivery suite had one birthing pool for pain relief and water birth. We were told this was mainly used by women having midwife-led births. However there were only a small number of water births because there was only one pool, so this option was not available to all mothers.

Pain relief in the midwife led unit (MLU) included massage, breathing and relaxation techniques, mobilisation and Entonox (a mixture of nitrous oxide and air). We saw pain scores used in women’s notes, including for women having epidurals. Women reported that they received pain relief when they needed it. They told us that they were given a choice in different stages of their labour.

Meptazinol or pethidine were available to women in early labour on the antenatal ward or triage. Entonox was not usually used on this ward. One woman reported she had not received pain relief in triage for 8 hours; however most women we spoke with reported good pain relief.

**Patient outcomes**

The RCOG Good Practice No. 7 (Maternity Dashboard: Clinical Performance and Governance Score Card) recommends the use of a maternity dashboard. The trust used a dashboard that had been developed by RCOG and was also used within the North West London Maternity Network. This enabled comparative data to be used across maternity units in North West London for benchmarking and peer review, as well as being used for internal monthly monitoring. CQC’s Intelligent Monitoring had found no maternity outliers for this trust.

We reviewed the dashboard for 2018. On many important indicators the service was successfully meeting national goals and there were no red rated outcomes. For example,
• 95.6% of women had one to one care in labour
• 54 % of women had normal labour, including women whose labour was induced. This is better than the mean national figure of 45% and met trust targets, and 17% of women gave birth in the midwife led unit.
• The number of elective caesareans carried out at the trust is lower than the England average at 10.2% compared to 12.1%. The number of emergency caesareans is higher than the England average at 19.2 % compared to 15.4% nationally. The trust goal was 16% which was in line with the North West London standard. The total number of caesareans was similar to the overall rate for England.
• There were 17.4% instrumental births with 3% failed instrumental births, which was better than expected failure rate.
• There had been 20 non-elective maternal readmissions this year. The trust did not set a target for this.
• The rate of babies stillborn at birth was 0.70%.
• The third or fourth degree tear rate was 3.6% of women and was below the expected range in the region, as was the rate of post-partum haemorrhage(PPH) at 2.2% (for blood loss under 1500ml) and 0.1% for massive PPH (blood loss over 4000 ml) and rate of puerperal sepsis which was 0.8%
• The proportion of induced labours was 28% compared to a national mean of 30%. This meant at this unit proportionately fewer women were having inductions, which carried risks of a more painful labour and a higher risk of caesarean section.

In the 2016 National Neonatal Audit, The Hillingdon Hospitals NHS Foundation Trust performance was as follows:

Do all babies of less than 32 weeks gestation have their temperature taken within an hour of birth?

Trust performance for this metric fell within the expected range, with 69.7% of babies included in this group having their temperature taken within an hour of birth. The national aspiration for this metric is 90%, however the national aggregate for England and Wales is 61% and Hillingdon were performing slightly better than this.

Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

The trust performed better than expected with 90.3% of mothers falling into this category receiving antenatal steroids. The national aspirational standard for this metric is 85%.
(Source: National Neonatal Audit Programme. Royal College of Physicians and Child Health)

Competent staff
Staff were supported to maintain and further develop their professional skills and experience by an active practice development team. This team were enthusiastic and committed to ensuring training events were effective and revising training to reflect new learning. Staff told us there were development opportunities and training was well planned and flexible.
Newly qualified midwives had an induction, followed a rotational preceptorship programme through different parts of the maternity unit. This programme was well-regarded by staff, although one newly qualified staff member said they had not always been supernumerary on clinical placements. They spoke highly of the support from the practice development team in enabling them to achieve their competencies with appropriate supervision. Student midwives received clinical education and felt welcomed and well supported by doctors and nurses.

Developmental programmes were available to midwives who were interested and had the support of their manager. For example there was a cardiotocography (CTG) masterclass, and a course on newborn life support. Some external courses were available. Staff said they felt well supported in the unit.

The trust had a grant from NHS Improvement to improve local teaching about the care of women with mental health problems. This included a workshop on perinatal mental health and an e-learning package on how to use the guidelines and protocols and how to refer women for additional help.

Following a study day on human factors, there were plans to introduce human factors training to a wider range of staff with another north west London hospital. CTG training already covered the need to include the woman’s wider clinical picture and the impact on decision making. Situational awareness would be added as another factor.

Trainee doctors followed a three and a half day induction programme. They said they felt well supported and protected and senior clinicians gave help and advice readily. They had time off to study for examinations. There was audit teaching, clinical governance teaching and a labour ward forum monthly. All the trainees said they would be happy to recommend friends to have a baby at Hillingdon. In relation to doctors in training, trainees requested to come to Hillingdon as a preference. There was good feedback in the GMC survey. This was similar to the last inspection where said the teaching and support from consultants was of a high standard.

Some 20 midwives were trained in the Newborn and Infant Physical Examination (NIPE). Hospital paediatricians were also carrying out NIPE checks.

All midwives were encouraged to attend mentorship training. We saw that study days were arranged on topics such as bereavement. Staff funded some external study days themselves, and in their own time.

Relevant midwives had Pegasus training on specialist counselling for genetics services and screening for sickle cell and thalassaemia. There were two genetics midwives, three diabetes midwives as well as specialised midwives for haemoglobinopathy (genetic blood disease), infection diseases and for atypical antibodies (antibodies produced by the mother that could damage the baby’s antibodies and cause blood disease of the fetus or newborn and one for raised BMI. Although 98% of women had booking appointments before 12 weeks, only 64% booked before 10 weeks. Midwives were seeking to increase this so that all women had the opportunity for early screening, and the number of earlier bookings was gradually growing through the year.
Appraisal rates
From April 2017 to November 2017, 99% of staff within maternity had received an appraisal. Midwifery staff took part in a well-established appraisal process, known as performance and development review. Staff told us appraisal was an opportunity to discuss training and development needs.

A split by staff group can be seen in the graph below:

<table>
<thead>
<tr>
<th>AC - Maternity</th>
<th>No. staff required (YTD)</th>
<th>No. staff who have received an appraisal (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>145</td>
<td>145</td>
<td>100%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>63</td>
<td>61</td>
<td>97%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Professional midwifery advocates (PMA) replaced the former supervisors of midwives on-call, since statutory supervision had ceased to exist in April 2017. The maternity unit had adopted the new model of midwifery supervision, independent of the unit’s management, early on. This was to help to support the large number of new midwives employed to support the higher birth rate that would follow the closure of Ealing hospital maternity services. The team of nine part time PMAs work closely with practice development midwives to provide advice and support to staff. A PMA was available on call 24 hours. Almost all PMAs had completed the shortened PMA preparation programme for those who had previously been supervisors of midwives. The PMAs supported midwives with revalidation.

Midwives told us the model of restorative clinical supervision supported quality improvement and preparedness for professional revalidation. The PMAs were visible in the unit and wore a distinctive uniform.

Multidisciplinary working
All necessary staff, including those in different teams and services, were involved in assessing women’s care and treatment. Women were seen by sonographers and some were seen by dietitians or doctors in other part the hospital as part of their care during pregnancy. When people received care from a range of different staff, teams or services, it was coordinated.

We observed obstetricians, anaesthetists and midwives working together on the delivery suite.

We observed effective multi-disciplinary working on the day assessment unit and antenatal ward. Teams worked well together and there was good communication.

The safeguarding team worked closely with external agencies such as Hillingdon children’s and adults’ social services, the UK border agency on trafficking and teenage pregnancy, voluntary services for asylum services, especially those with no recourse to public funds, and the Multi
Agency Safeguarding Hub, and school nurses for teenage pregnancy. These were effective two-way relationships and staff were confident that women were unlikely to be missed.

Obstetricians held weekly meetings with the neonatal team to discuss known baby risk factors before delivery as well as incidents including unplanned term admissions to the neonatal unit from the midwife led unit and labour ward. Admissions in the year to date were running above the goal of fewer than 4% at 4.9% and staff were analysing the reasons for this.

The unit worked with general practitioners (GPs) with an interest in maternity, even though GPs no longer provided antenatal care. There were occasional GP bulletins and meetings covering issues such as pre-conception care and identifying women in vulnerable circumstances.

There were clinics for high-risk women with medical problems such as diabetes or epilepsy. Women with cardiac problems had shared care with another local trust.

**Seven-day services**
Consultants worked seven days a week and a consultant was on site for six hours a day at weekends on the delivery suite.

A dedicated triage unit was staffed 24 hours a day.

The early gynaecology ambulatory unit (EGAU) was open 8am to 4.30pm Monday to Friday and a half day on Sunday. It had scanning facilities on site. The unit accepted referrals from GPs, midwives, the emergency department or an urgent care centre, and aimed to see patients on the same day or within two days of receiving the referral. Patients with a past history of molar pregnancy or ectopic pregnancy could self-refer.

**Health promotion**
Women received Wellbeing wallets in which to keep their hand held notes. These were developed by a national pregnancy charity for educating mothers and midwives, MAMA academy and were colourfully printed with important advice on the mother’s health, and that of her baby. This ensured that key messages such as monitoring babies’ movements and when to contact the maternity unit were promoted to women. The folder also reminded women about stopping smoking, avoiding alcohol and smoking cessation.

Women also received information about family planning and sexual health.

In the antenatal unit there were top tips for health shown on a display screen, about exercise and folic acid, as well as safety alerts.

The post-natal wards gave women a booklet ‘After your baby’s birth’ about the health and wellbeing of both mother and baby after birth, with a range of contacts for advice and help in identifying urgent issues. This new booklet was available in Arabic and Gujerati with further translations planned. It included a section on emotional and mental health with information on how to get help. The content supplemented information in the magazine ‘Mothers and others which the staff gave women early in pregnancy on pregnancy, feeding and parenting. Content was based on the latest evidence and research in maternity care and contained clear and helpful advice.
As a result of two incidents in maternity there was now better co-ordinated mental health provision for pregnant woman and mothers. There was a dedicated perinatal mental health clinic jointly run by a team including a consultant obstetrician, consultant psychiatrist, a perinatal mental health nurse and psychologist. The care from this team could continue up to a year after birth. There were good pathways for women with mental health needs.

A consultant obstetrician and a midwife with expertise in dietary health and exercise ran a plus-size clinic for women during pregnancy. They set up this service to support the growing need within their local population, to advise women of the health risks, and support them to reduce excess weight gain during pregnancy. Women received one-to-one advice and help on how to eat healthily in pregnancy and after the baby was born, together with practical advice on exercise.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
Consent was part of mandatory training for midwifery and obstetric staff. Arrangements were in place to seek consent for surgery and other procedures, including screening. Consent forms were appropriately signed in the maternity notes we reviewed. Staff told us they considered capacity to give consent and demonstrated a working knowledge of the Mental Capacity Act (MCA) and its implications. Eligible staff attend enhanced MCA and DoLS training once only, with a refresher every 3 years as part of Safeguarding Adults Training. We observed staff asking for verbal consent before physical examinations.

The self-referral form for booking maternity services gave an option to consent to contact by mobile, by text and by NHS messages. There was no request for consent to leave messages on an answerphone.

Consent was audited as part of the audit of the World Health Organisation (WHO) surgical safety checklist, and in documentation audits.

Is the service caring?

Compassionate care
We saw evidence of care being delivered that was kind and compassionate. Women were very complimentary about staff, and said they felt comfortable with staff and their privacy and dignity were maintained. The independent Healthwatch study reported on the basis of many interviews and surveys of women that staff gave compassionate care. One woman told us “Midwives have a passion that gives you confidence”, others reported that they were coming to Hillingdon because other family members had reported good experiences.

We saw many positive comments in letters and cards to the staff. One wrote of “high standards of professionalism”, another commented on ‘all staff being incredibly compassionate, respectful, patient and supportive’, another commented on the “professional, warm bedside manner” of staff. One woman wrote “the care I received was like nothing I could have hoped for”.

The Friends and Family Test (FFT) is a measure of patient satisfaction. The maternity service response rate was 23%, higher than the 20% target. Patient satisfaction was 97%, which was above the target of 94%. Staff monitored FFT returns weekly and proactively encouraged women to give feedback.
From November 2016 to October 2017 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average for the entire 12 month period.

The most recent results for January 2018 show the trust’s score for antenatal care to be 91%

From November 2016 to October 2017 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally similar to the England average for the entire 12 month period. The results for January 2018 showed the trust’s score to be 99% which was above the England average of 96%.

From November 2016 to October 2017 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average for the entire 12 month period.
The results from January 2018 show the trust’s score to be 98%, above the England average of 94%.

**Friends and family test performance (postnatal community), The Hillingdon Hospitals NHS Foundation Trust**

![Graph showing performance over time](image)

From November 2016 to October 2017 the trust’s maternity friends and family test (postnatal community) performance (% recommended) was generally similar to the England average. No data was submitted for February 2017.

The results from January 2018 show the trust’s score to be 100%, above the England average of 98%.
(Source: NHS England Friends and Family Test)

**Emotional support**

We spoke with two mothers in antenatal clinics. They described receiving clear and helpful advice and reassurance. Women could access support for specific health issues such as diabetes or mental health needs. Midwives assessed women’s mood during antenatal visits in line with NICE clinical guideline 192 and could refer women for support with anxiety and depression.

We saw that two specialist bereavement midwives provided sensitive and compassionate care to women or couples, as well as practical support while they were in the hospital. The team also provided training to other staff. When women lost a baby, bereavement midwives talked to the families about sensitive disposal of the remains. Memory boxes were offered to parents who had lost a baby. A clinical psychologist was on site who offered counselling to couples who wanted an appointment with her. A multi faith chaplaincy service was also available to provide support.

At present staff used a delivery room at the end of the delivery suit in cases of bereavement but midwives were working with a charity to secure funding for a separate bereavement suite which could be accessed from outside the unit to give more privacy.

Staff understood the personal, cultural, social and religious needs of women from the various communities using the service.

**Understanding and involvement of patients and those close to them**

Women we spoke with said midwives had supported them in making decisions about their care. They felt able to ask staff if they were unsure about something. Staff introduced themselves and explained what they were going to do and why. Women were pleased with the explanations and
the way staff responded. We noted that staff gave women written information to supplement the information given verbally which was in line with good practice.

Two partners told us they felt staff helped them feel involved in the birth. and were given the opportunity to ask questions.

The midwifery advocates offered a listening service for women who wanted to talk about the events surrounding the birth, why possible intervention was necessary and to talk about their feelings. This was advertised on the postnatal ward.

There was plenty of information available in other languages and interpreters and telephone translation were used. However we observed one occasion where a staff member did not check the understanding of a woman for whom English was not the first language and we spotted that the family had not understood the information given.

Women were enabled to manage their own health and care through receiving information to help them improve their diet and take exercise.

**Is the service responsive?**

### Service delivery to meet the needs of local people

Women could refer themselves to the maternity unit or be referred by their GP. The majority of women referred themselves. The unit ran twice weekly information sessions on birth place choice. Women were able to tour the whole maternity unit in advance of giving birth.

Antenatal and postnatal services were provided in community locations, mainly children’s centres, reducing women’s need to travel to the hospital. Each children’s centre had a named midwife. There was a home birth team for women who chose to give birth at home and were assessed as safe to do so. These women had full continuity of care from this team. Some consultant led clinics were run at Ealing and Mount Vernon hospitals as well as at Hillingdon.

The service had four midwifery led care teams, known as Coral, Emerald, Amber and Sapphire which covered different areas. A specialist team, Topaz handled a caseload of women with complex social and medical needs.

At the last inspection continuity of antenatal care was not always provided. At this inspection, as part of the Better Births programme, the clinical commissioning group (CCG) was supporting the hospital to improve continuity of care so that women would see members of a small team of midwives. Different models of providing continuity were being trialled. The maternity unit aimed to achieve continuity for 20% of women by 2019, in line with the region’s local maternity systems plan. The aspiration was for a woman to have care from two midwives during their antenatal care.

Staff in one team were trialling a ‘meet the team’ booklet for community midwifery, which showed photographs of the team so women would recognise all members of the team. They also gave mothers a template at 36-38 weeks to help them plan ahead for their postnatal care. Another midwifery team were trialling a scheme where women would have antenatal, intrapartum and postnatal care from the same midwife. One possibility for achieving this was for the woman’s usual midwife to be on call at the time of the birth, if they could not actually be present, and give
reassurance that way. Another way of achieving continuity being tested was for women over 30 weeks on the midwife led pathway, who would give birth in the midwifery led unit (MLU), having continuity of care at birth and postnatally by returning to the birth centre for their Day 10 check.

There was a café in the antenatal clinic area, and a baby shop in the entrance to the maternity unit. Staff arranged women’s clinic appointments as far as possible so women could have antenatal checks, scans if needed and blood tests on the same visit. Women told us they were generally able to schedule appointments around work or family commitments. They received appointment reminders by text/SMS, although the hospital arranged scan appointments by letter.

Parenting education was offered to women and their birth partners who were having their first baby. Midwives and health visitors jointly ran classes over six weeks at the children’s centres. There were also one day workshops at the hospital. These classes and workshops were free. In addition the hospital offered Welcoming our baby’ private classes at a cost of £150 for a block of four sessions.

There was a Maternity Day Unit (MDU) for assessment for pregnancy specific concerns in women over 20 weeks including reduced fetal movement, presentation scans, CTG monitoring or for concerns about pre-eclampsia. This four bay unit was in the main maternity unit with easy access to the delivery suite or the antenatal/postnatal ward.

The obstetric-led delivery suite provided for all eligible women over 18 weeks gestation. However, women who might give birth before 28 weeks were usually transferred to the nearest hospital with a level 3 neonatal unit as their babies were likely to need a higher level of care.

The facilities and premises were appropriate for the delivery of the service. Rooms on the delivery suite had built in music systems, had ensuite facilities and new equipment. Partners could stay overnight if a woman was in early labour. Women could have two birth partners.

Mothers told us staff were welcoming to partners on the post-natal ward, and that staff were gentle and supportive. Minor complaints were a shortage of pillows, backless hospital gowns which did not provide dignity, and the lack of daily changes of bedlinen.

Women reported that the meal quality was good. Food scored above average in PLACE Patient-Led Assessments of the Care Environment (PLACE) Programme, at 97% for ward food. One person remarked that catering staff served ‘ethnic’ meals in foil containers rather than on a plate. However was no fridge for women to keep their own food on the postnatal ward or facilities to heat their own food. Staff could heat up meals that families brought in.

We saw good quality information available to mothers, for example a ‘Mothers and others guide’ and a baby buddy application (app). The app had hundreds of short videos and information to support the information midwives gave to mothers-to be and new parents. It was free to download and midwives were able to help women download and use this app.

**Meeting people’s individual needs**

Staff had an understanding of the different needs of the local population. The service had set up meetings within in the past year with some hard to reach communities, such as Somali speakers,
to improve understanding of the way women could access maternity services. There were many
different ethnic groups in the two boroughs. About 16% of residents in the Hillingdon were
reported as not speaking English well. The trust policy was to use interpreters at booking
appointments and in consultant appointments. Staff could arrange interpreters with notice and
occasionally on the same day. Staff said women sometimes asked to use family members for
translation, in which case staff had to make a judgement about whether this was acceptable while
recognising that this was not best practice. We saw translation needs discussed as part of
handover on delivery suite.

Staff said the most spoken languages in Hillingdon were Punjabi (3.4%) and Polish (1.5%). In the
borough of Ealing Polish (6.3%), Punjabi (5.1%) and Arabic (2.2%) were the most spoken
languages. More recently Somali and Afghan speakers had come into the area. The service
provided maternity care for Irish traveller and Roma families who lived in different parts of the
borough.

Information on the website and in the hospital was in English but there were a number of leaflets
on the website and in the hospital in other languages. On the back of all leaflets there was
information in seven languages about how to obtain information in alternative formats. We saw
staff in the delivery suite discussing translation needs at handover. The generic postnatal pack
had links to information in other languages, and the breastfeeding DVD had subtitles in 12 other
languages. Staff on the unit were aware, and could demonstrate, how they would access
interpreting services for people who did not speak English as a first language.

There was wheelchair access to the wards and delivery suite. All the rooms had accessible
bathrooms and showers, and the antenatal and postnatal wards had rooms suitable for people
with reduced mobility. Staff said they could provide a specialist in sign language or visual aids for
women with hearing problems. The needs of women with sight problems or learning disabilities
would be individually assessed. A learning disability adult nurse was available to support staff and
women with a learning difficulty as needed.

A specialist midwife for substance misuse on the complex care team could support women and
their partners regarding substance use in pregnancy and the effects on outcome and
interventions. There would usually be a referral to social care.

A Talking Therapies Service run by another local trust held drop-in sessions at Hillingdon Hospital
to help women to learn new coping strategies to relax and feel more positive about pregnancy.

There were private amenity rooms on the post-natal ward for which women could pay for if they
wanted privacy. However priority went to women who had a social or medical need for a private
room so these rooms were not always available. Posters reminded people to knock before
entering rooms to protect patient dignity.

At the last inspection there had been no dedicated room for bereaved mothers. There was now an
allocated room, with a sofa bed, although this was sometimes used as delivery room when the unit
was busy. There was a cooling cot so parents could spend longer with their baby.

The postnatal ward had six beds for transitional care which enabled women and babies to remain
together rather than being cared for in the neonatal unit. Babies who needed treatment such as
antibiotic medication stayed with their mothers.
The early pregnancy assessment unit (EPAU) offered care and support to women experiencing complications in early pregnancy (less than 18 weeks gestation), such as miscarriage, ectopic pregnancy, molar pregnancies, fetal abnormality, vaginal bleeding or pelvic pain. The unit was in the gynaecology ward which had its own scanning facilities. Women were advised to attend the emergency department out of hours.

Women with hyperemesis (sickness in early pregnancy) were usually treated as day cases in the gynaecology ward. There were two chairs for these ambulatory patients where they could receive IV fluids without hospital admission.

Women were given options about the disposal of pregnancy remains which was in line with the guidance from the Human Tissue Authority. There was a sensitively produced booklet with details of how to make funeral arrangements for pregnancy loss, including burial or cremation. The mortuary had tight procedures for baby viewings. They arranged post mortems with the regional genetics service for babies who had died before, during or shortly after birth. Consent forms for post mortems had been audited in 2017 and the results presented to the annual maternity bereavement training day to improve recording practice.

There was a plan in place for the safeguarding team to offer a 24 hour telephone support service to women who were pregnant or who had recently given birth, from 1 April 2018 which was innovative and would provide readily available support for the women using the maternity service who were in the most vulnerable circumstances.

Women attending the termination of pregnancy service were treated in the gynaecology ward in line with good practice. Women who had suffered an intrauterine death in later pregnancy were seen on the delivery suite.

At the last inspection there was no dedicated high dependency area and women requiring high-level care following surgery were taken to the main intensive care unit, which meant they received appropriate care, but were separated from their babies. There were now two beds in the delivery suite. Nurses were being recruited to care for these women, and would also work on the wards when there were no women needing high dependency care. Only five women had needed HDU care in the year to date.

The Hillingdon Hospital offered private obstetrics. Several consultants offered a package of care for women who wished have all their appointments and delivery with a consultant obstetrician. We did not inspect this service.

Women on the antenatal ward praised staff for managing well when the ward was extremely busy; they said they felt personally cared for. However some women on the antenatal ward mentioned that doctors were not often on this ward which delayed decision making. They also said there was a lack of privacy for medical discussions.

Women received support with breast feeding from the maternity support workers and at peer support groups in drop in centres at local children’s centres. These were advertised on Facebook and in antenatal clinics and GP surgeries.
Since the last inspection the trust had opened a transitional care unit so that babies who needed additional nursing care and monitoring could stay with their mother rather than being in the Special care Baby Unit. Midwives monitored mothers and neonatal staff, based on the same floor, monitored babies.

**Access and flow**

Clinic waiting times were monitored and 93% of women were seen on time. We saw that if a clinic in the hospital was running late, this was noted on the white board and women said they were kept updated on delays.

Women attending antenatal clinics had text reminders and were asked to telephone to reschedule if they could not attend. The safeguarding team followed a clear protocol on women who missed two or more appointments. This included home visits. If a woman appeared to have moved home and staff were unsure of their whereabouts, a missing person safeguarding alert would be raised.

Women in labour were admitted through the maternity triage where they were assessed by a midwife and transferred to the delivery suite if needed.

Bed occupancy was 57% at its highest. This was below the national average of 62%. From April 2016 to September 2017, the bed occupancy levels for maternity were lower than the England average during the entire period. The highest levels were seen in Q1 2016/17 with the trust reaching around 57% occupancy. For the remainder of the period, the trust fluctuated between 25% and 35%.

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)
Women were helped to develop birth plans according to their level of risk; these ensured that they were cared for in the most appropriate area during labour. Women who were low risk followed the midwifery led pathway. Women were able to go home after six hours from the midwife led unit if staff felt they were ready.

Midwives gave new mothers an information pack before discharge from the postnatal ward. Plans for follow-up clinics were made for women who had third and fourth degree trauma.

There was good information sharing between teams. We observed very effective communications between the antenatal ward, triage and the delivery suite including a daily multidisciplinary meeting to predict discharges and enable planning of work on the delivery suite. There was also weekly planning in relation to women whose babies might need admission to the neonatal unit.

At times during our inspection the delivery suite was very busy and some women experienced delays in transfer to the delivery suite following induction. Staff said delays rarely affected women in established labour but accepted that the antenatal wards were currently not a satisfactory environment for women in early labour. The hospital had a longer term plan to provide more privacy for women in early labour through having an induction area separate from the antenatal ward.

Women and young people seeking an abortion were referred to third party providers. The trust offered medical abortion to women who had attended antenatal clinics who needed removal of products of conception because of a failed pregnancy these women were treated in the gynaecology ward, or in the delivery suite if in the later stages of pregnancy, in line with good practice, and were given a choice when this was appropriate. Women needing urgent treatment for ectopic pregnancy were added to the emergency day surgery list where slots were always held to avoid delay.

**Learning from complaints and concerns**

Information about how to report concerns was available to women and families. We saw leaflets from the patient advice and liaison services service (PALS) in the antenatal clinic and wards as well as information on the trust website. We asked six women whether they knew the procedures for raising complaints and concerns. All were aware of the processes and the availability of the (PALS) but none had any significant complaints.

Staff told us they always tried to resolve concerns locally. If a woman or family had a concern they were encouraged to speak to midwives on the ward.

From April 2017 to January 2017 there were 20 complaints about maternity services. The trust took an average of 36 days to investigate and close complaints. Trust policy was to close 90% of all complaints within 30 days. Over the year from April 2017 to March 2018 the division closed 87.8% of all complaints within 30 days.

The main theme of complaints was clinical treatment. Of the 17 complaints in the previous year, to November 2017, seven were partially upheld, and three of the eight complaints about the postnatal ward were partially upheld.

(Source: Provider Information Request - Complaints)
Staff told us there had been no formal complaints in February 2018.

**Is the service well-led?**

**Leadership**
The Head of Midwifery lead the maternity service alongside a lead obstetrician. Midwifery leadership was shared effectively among a number of staff with responsibility for specialist areas. There was a lead for antenatal care and community midwives and other specialist midwife roles included a consultant midwife for normal birth, two clinical risk midwives, a matron, labour ward manager and clinical practice facilitator. Named midwives led the wards and delivery suite. Leaders at every level were known to all staff. The benefit of shared leadership was demonstrated to inspection by the ability of staff to demonstrate knowledge of the issues and priorities in the service and the challenges, in the absence on leave of the head of midwifery. An interview with the head of midwifery after the inspection corroborated what we had heard, indicating good communication and understanding of the service throughout the unit.

Staff told us the head of midwifery was visible and approachable, and led by example with passion and commitment, and worked effectively with the obstetric leads. The lead midwives and obstetricians were knowledgeable about issues and priorities for the quality and sustainability of services, understood what the challenges were and acted to address them.

Trainee doctors praised labour ward obstetric and midwife leadership. They valued the effective planning meetings to look at elective caesareans and inductions, and release slots if a patient delivered earlier. All medical trainees rated care, leadership, resources and safety as good.

Midwives on the midwife led unit reported strong support from the consultant midwife.

There was a trust board governor for maternity.

**Vision and strategy**
The vision of the service was to provide safe local maternity care for local women, and to increase the proportion of women having normal births. Their vision was clearly rooted in the Shaping a Healthy Future programme for the area, which we found all staff were aware of.

The 2016 national maternity review published its report “Better Births, Improving outcomes of maternity services in England” in February 2016, which set out the five year forward plan for maternity services across the country. The changes at Hillingdon and in the NW London region were aligned with this national vision and the area was already delivering the majority of the standards of care outlined in the review. They were trialling alternative models to improve continuity of care and were working to achieve the national aims to reduce poor outcomes for women and babies by 20% by 2020 and 50% by 2025.

Staff considered they were achieving the objectives of the services within the constraints of existing funding. If funding became available the maternity aimed to provide an induction suite to give women more privacy in early labour than was possible on the antenatal ward. There were also plans for the provision of a dedicated bereavement suite for which charitable funding was being sought.
There had been some physical challenges caused by fitting a larger maternity service into the same building. There was a plan, subject to funding, to extend the maternity block and carry out some backlog maintenance.

**Culture**

All the staff we spoke with felt well motivated and supported by other staff in the unit, both managers and their peers. They were proud of the service they offered. Staff told us there was little hierarchy and said they could approach any member of staff for help and would receive it. Although the unit was medium sized, it had the friendly and cohesive feel of a smaller unit.

Managers were flexible in helping with shift patterns to accommodate people’s domestic or health needs. Staff felt the trust was a good employer, and we spoke with a number of staff who travelled long distances to work in the unit because they valued the excellent team working and supportive culture. Some staff had returned to work at the trust because of the friendly team. The unit kept staff informed through keep in touch days when they were on maternity leave. For staff that chose to retire at 55 there was a ‘retire and return’ scheme where staff could return to work part time, including working on the bank. Many such staff worked for a number of years so their experience was not lost to the hospital. The unit offered honorary contracts for midwives seeking to improve their English language skills.

Staff were aware of the CARES values of the trust: putting people first, with a focus on good communication, attitude, responsibility, equity and safety.

The unit celebrated success in highlighting staff good practice through a new scheme known as Greatix, which the women’s division was piloting. The aim of the Greatix scheme was to report excellence as a way of learning, in parallel to reporting incidents for learning. The aim was to highlight ways to improve the service, good role models, and raise staff morale, share best practice and create a good working environment.

Staff were able to demonstrate how they delivered care and services in line with the duty of candour. This included being open and honest in their communication and discussing accidents, incidents and mistakes with patients and their partners.

**Governance**

Maternity was within the Women’s and Children’s services division, and the management structure included gynaecology and paediatrics. The structure of the division and the processes and systems of accountability were well understood by staff and effective.

The service had systematic governance processes that provided good assurance on performance, safety and risk which took account of quality and sustainability to the trust board. The women and children division executive board set the strategic priorities for governance and monitored by exception. The maternity strategy board provided support and scrutiny on key performance and quality standards. The maternity governance group addressed governance and clinical and non-clinical risk. The monthly multidisciplinary meetings were chaired by the obstetric clinical lead for risk supported by the head of midwifery. The meetings followed a standard comprehensive
agenda including reviewing the status of any unresolved actions in relation to minimising risk from previous meetings so ensuring that progress was monitored in all areas.

The main incident review meeting, also monthly, reviewed and examined incidents and identified trends for inclusion on the risk register. We noted that lessons learned from serious incidents were very well disseminated to staff. The governance teams and senior clinical staff shared lessons learned with ward teams through monthly meetings. In some cases midwifes were given responsibility for leading on issues identified from themes of incidents. A recent example was catheter care, to ensure actions in the action plan were followed through. Performance in catheter care which had averaged 58% in April 2017 had risen to 100% in January 2018.

A labour ward forum to review issues specific to the labour ward, and there were other steering groups for antenatal and postnatal care, as well as a perinatal mortality meeting, and a maternity guidelines group.

The maternity strategy board reported to the trust Patient Safety and Quality Committee. Maternity reports were presented to the trust board twice a year.

**Management of risk, issues and performance**

The unit had responded to the challenge of a change in the demographic of their maternity population by increasing safeguarding arrangements. To meet the needs of the people living in a wider catchment area, clinics continued to run in Ealing and at Mount Vernon hospital to reduce women’s need to travel. There was a regional agreement to a cap on bookings to ensure numbers of women were within the number the hospital could cope with. The maternity unit had received praise from the clinical commissioning groups (CCGs) on a smooth and safe transition.

A risk register was used to identify risks, provide action plans and update guidelines and procedures in the department. Risks were identified and mitigations put in place with systematic monitoring through the maternity governance group.

We did not identify any risks that were not on the risk register. The highest risks on the risk register at the end of November 2017 had been estates and equipment issues including: obsolete anaesthetic machines. One new machine was for delivery in March 2018 and the other due in April 2018; we saw evidence that maintenance contracts had been set up for both. There had been a concern about security and we saw that CCTV cameras had been replaced and there was an imminent repair date for the external door that did not close. Theatre ventilation issues identified at the previous inspection had been resolved.

The clinical audit programme was focused on areas of potential risk which was in line with good practice and audits were completed in a timely way. Staff were aware of the results of audits and action plans where changes were needed.

Senior staff reviewed the unit’s performance against action plans from national reports such as Each Baby Counts and Saving Babies Lives’ to check that they met best practice. They performed very well against these comparisons. They only rated themselves as non-compliant against one item: the National Maternity and Perinatal Audit on the need to audit elective deliveries prior to 39
weeks to ensure there was a clinical indication. An audit was planned to check this and would recommend improvements if required.

A maternity dashboard was used proactively to record activity and management data, as well as clinical indicators, and provided a monthly record of performance against targets. It was a tool to monitor trends and risks especially relating to safety and helped to identify potential harm to patients. It was monitored monthly at the Maternity Governance Group and within the NW London sector maternity group.

The risk midwife reviewed all maternity incidents every day, and ran weekly meetings to review significant incidents. This midwife produced a risk newsletter, Gossip Corner, each month to share learning from incidents and complaints. We saw copies on display on noticeboards.

Staff were proud of the smoothly executed transition from the closure of Ealing maternity services. In which they actively managed risks and planned for contingencies as they made changes to accommodate the potential increase of 800 births. Changes made had involved the introduction of transitional care on the post-natal ward, the midwife led birth unit, and reorganisation of the day unit and triage. These changes, which took place in a short space of time, involved employing 60 new staff. The involvement of the new professional midwifery advocates had provided invaluable support to the high proportion of newly qualified staff on preceptorships.

**Information management**

Staff reported the information technology as adequate, although some systems were not interoperable. Ultrasound and blood results were not reported on the main maternity information system. However, the system did communicate with the neonatal computer system and the hospital patient administration (PAS) system. To ensure the information used in reporting and performance management was accurate, staff took a weekly extract of the electronic data record to identify and correct incomplete data, and where necessary follow up incomplete records with individuals.

Obstetricians used an electronic diary to book patients for induction and caesarean section when they were working at clinics in other hospitals. Planning for induction of labour took account of activity or capacity on the delivery suite to ensure there would be a delivery suite bed available. Three inductions were normally the maximum in a day.

A communications brief covered trust updates, HR and finance updates and welcomes to new staff.

Community midwives had some access to trust computer systems in the community although coverage was patchy.

**Engagement**

The service was an active participant in the local maternity system for North West London local maternity system, set up by NHS England to bring together providers and commissioners of maternity services to design and delivery services of populations of 500,000 – 1,500,000 people. The maternity changes had been part of the clinically led Shaping a Healthier Future (SaHF)
programme to improve healthcare for people of North West London. This programme had enabled the maternity service to have more midwives and senior consultants, upgrade its maternity facilities and provide more antenatal postnatal care locally and offer greater birth choice.

The trust was setting up a new maternity voices partnership (MVP) an advisory group made up of professionals and parents working in partnership, including staff, representatives of clinical commissioning groups (CCGs). The MVP were discussing how to involve parents who have used the services in the last five years. There were some challenges in getting representative input, because so many women had English as an additional language. We also saw evidence of engagement between maternity services and the local Health watch group who had reviewed the service after the SaHF transition.

The service engaged well with staff using various media. There was communication through ward briefs (updates on clinical and non-clinical matters), team briefs (saw an example that covered wound care, bladder care, IPC, safeguarding), Gossip corner (the risk bulletin) and monthly team meetings. Team meetings were held in the morning so both day and night staff could attend before the end or start of their shifts.

**Learning, continuous improvement and innovation**

There was a strong focus on continuous learning and improvement at all levels of the organisation, led by the risk midwives in particular. Data was analysed for themes and trends and findings were disseminated.

The service had run a ‘Whose Shoes?’ session in November 2017. The results were captured in cartoon form displayed in the maternity unit. This process enabled staff to look at how they worked with women and families on a day-today basis, the language they used with women and each other, and how they conducted ward rounds on the delivery suite and to review the whole experience for women and their family using the maternity service. This had been helpful in highlighting potential problems of attitude and communication between staff and patients.

As part of the Maternal and Neonatal Health Safety Collaborative the unit was involved in a three-year programme, launched in February 2017, to support maternal and neonatal care services to provide a safe, reliable and quality healthcare experience, to create the conditions for continuous improvement, a safety culture and a national maternal and neonatal learning system, as well as contributing to the national ambition of reducing the rates of maternal and neonatal deaths, stillbirths, and perinatal brain injuries by 20% by 2020.

The unit were also involved in a national project to improve processing of urgent maternity and neonatal blood tests to reduce delay in both diagnosis and treatment of women presenting with clinical concerns, and scanning for cervical length in women at risk of preterm births.

The delivery suite displayed Awards for Enhanced Recovery staff (2015), an Outstanding Team award (2015), a Quality and Innovation Award for maternity bereavement, and the Mary Seakale Award 2016 for raising awareness of female genital mutilation, and working with victims, their partners and families.

The plan to provide 24 hour support for women with complex social needs was innovative. This new service would be evaluated in six months.
The team had identified a simple but effective solution to the problem of urinary retention when women had a catheter removed. Posters in toilets and postnatal wards gave women a 5 point plan to prompt them drink enough to ensure their bladder was working properly.

Midwives and maternity support workers could access a digital app to opt in to bank shifts. This had improved the fill rate of shifts. They also had a closed Facebook page for information on study days to supplement formal channels of information such as newsletters and team meetings.
Services for children and young people

Facts and data about this service

The trust has 33 inpatient paediatric beds across two wards at Hillingdon Hospital:

- Peter Pan ward: 24 beds
- Wendy ward: Nine beds

(Source: Routine Trust Provider Information Request (RPIR) – Sites Acute tab)

The trust had 5,533 spells from October 2016 to September 2017. Emergency spells accounted for 90% (4,982 spells), 9% (514 spells) were day case spells, and the remaining 1% (37 spells) were elective.

The children’s outpatients department provided numerous specialties including diabetes, neurology, allergy, respiratory, endocrine and baby. Children with other problems such as eye, ENT and dental are seen in other departments of the hospital.

Percentage of spells in children’s services by type of appointment and site, from October 2016 to September 2017, The Hillingdon Hospitals NHS Foundation Trust

[Graph showing percentage distribution of spells]

Total number of children’s spells by Site, The Hillingdon Hospitals NHS Foundation Trust.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hillingdon Hospital</td>
<td>5,531</td>
</tr>
<tr>
<td>This trust</td>
<td>5,533</td>
</tr>
<tr>
<td>England Total</td>
<td>1,102,315</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

The trust set targets between 80-95% for completion of mandatory training.

A breakdown of compliance for mandatory courses from April 2017 to November 2017 for all staff in children’s and young people’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained (YTD)</th>
<th>Number eligible (YTD)</th>
<th>Completion (%) YTD</th>
<th>Target Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>90%</td>
<td>19</td>
<td>19</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>80%</td>
<td>165</td>
<td>168</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>80%</td>
<td>165</td>
<td>168</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>80%</td>
<td>94</td>
<td>96</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Corporate Induction</td>
<td>80%</td>
<td>43</td>
<td>44</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>80%</td>
<td>162</td>
<td>168</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>80%</td>
<td>132</td>
<td>137</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>160</td>
<td>168</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>90%</td>
<td>140</td>
<td>148</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>80%</td>
<td>152</td>
<td>162</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 3 years</td>
<td>80%</td>
<td>52</td>
<td>56</td>
<td>93%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>80%</td>
<td>103</td>
<td>111</td>
<td>93%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>80%</td>
<td>59</td>
<td>72</td>
<td>82%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>1446</strong></td>
<td><strong>1517</strong></td>
<td><strong>95%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All 13 mandatory training modules met the trust target in children and young people’s services.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

There was an induction process for all new starters which included a week long corporate induction where mandatory training was undertaken followed by a second week of local induction which included orientation, shadowing and a practice shift.

Temporary (agency) staff had a local induction process which included orientation on the wards, fire safety, resuscitation trolleys and the details of relevant members of staff such as trust leads and the nurse in charge.

Mandatory training was undertaken either by online e-learning or face to face sessions. Staff told us that they were given protected time to undertake training and had access to computers for this purpose.

**Safeguarding**
All staff we spoke with demonstrated a good understanding of safeguarding children and young people and were able to describe signs and symptoms that would prompt them to make a referral. Staff knew who the named safeguarding leads were and how they would raise safeguarding concerns or seek advice.

There was information available for staff around the wards and on the intranet including relevant telephone numbers and contact details for the safeguarding leads.

Safeguarding information was recorded on the electronic patient records system and was accessible for staff.

There was a protocol in place for children received from Heathrow Airport. Children would be accompanied by a Border Force officer and would have additional identity checks.

The trust had an infant abduction policy which staff knew how to access on the intranet. The policy covered the procedure for notifying appropriate managers and agencies, documentation of the incident and debriefing of staff afterwards.

The trust had a Prevent policy in place and staff had an understanding of their duties to safeguarding children and young people from the risk of radicalisation. There was a Prevent lead for the trust.

Staff we spoke with had a good understanding of the identification of female genital mutilation (FGM) and there was a protocol in place for escalation. FGM was incorporated into the safeguarding training carried out by all staff including signs and symptoms and identifying those at risk. Staff felt comfortable reporting and escalating concerns.

The trust took part in local multi-agency committees on child sexual exploitation and FGM and was moving towards implementing a hub model in the local health and social care economy with Hillingdon Hospital at the centre.

Multi-disciplinary ‘Safety net’ meetings were held once a week to review and provide updates on safeguarding cases and risks in the hospital. The meeting reviewed all incidents and referrals and looked at all fractures in children under two years old and instances where children did not attend or were not brought to their appointments.

Data provided by the trust showed that 238 safeguarding referrals were made in the reporting period.

Safeguarding children formed part of the trust’s mandatory training programme. All staff who had contact with children completed safeguarding level three training. The trust set targets between 80-90% for completion of safeguarding training and met these targets across all training levels and staffing groups.

A breakdown of compliance for safeguarding courses from April 2017 to November 2017 for all staff in children and young people’s services is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained (YTD)</th>
<th>Number eligible (YTD)</th>
<th>Completion (%) YTD</th>
<th>Target Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 4)</td>
<td>90%</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>90%</td>
<td>165</td>
<td>168</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>90%</td>
<td>151</td>
<td>154</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>90%</td>
<td>119</td>
<td>122</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>80%</td>
<td>160</td>
<td>168</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>597</td>
<td>614</td>
<td>97%</td>
<td></td>
</tr>
</tbody>
</table>

All five safeguarding training modules met the trust target in children and young people’s services.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Cleanliness, infection control and hygiene

In the CQC Children and Young People’s Survey 2016 the trust scored 8.27 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts. (Source: CQC Children and Young People’s Survey 2016, RCPCH)

We requested data covering the number of cases of MRSA and C. difficile in the department but this information was not provided by the trust.

All of the children and young people clinical areas for we observed were visibly clean and clutter free. There were antibacterial hand sanitiser dispensers available throughout the department and hand cleaning instructions at sinks.

There was personal protective equipment such as gloves and aprons available for staff throughout the department and we observed staff using it. All staff we observed on inspection were bare below the elbows and staff we spoke with told us they would challenge colleagues if they were not compliant with cleanliness and infection control protocols.

There was an infection prevention and control (IPC) link nurse in the paediatric department and also a paediatric link in the IPC team to coordinate IPC in all paediatric areas. Staff we spoke with were aware of who the IPC link was and how to contact them.

We observed staff following hand hygiene protocols such as wearing gloves, using antibacterial gel and washing their hands appropriately. Parents and patients we spoke confirmed that staff always washed their hands before they cared for patients.

Environment and equipment

Both wards and the outpatients area were clean and tidy during our inspection. Equipment had recently been tested for electrical safety and was kept clean. There was a newly built ‘wing’ on Peter Pan ward with en-suite rooms. The environment in this area was noticeably brighter and more modern than the older parts of the wards.
There was a buzzer system at the entrances to the children’s department with security cameras and a passcode system so staff could monitor and control who entered the ward.

We looked at resuscitation trolleys in the department which were available on both wards. We saw that all were fully stocked and daily checks were carried out on their contents in accordance with hospital policy. Staff signed a log to demonstrate that the checks had been carried out. The trolleys were secured with plastic tamper proof locks.

Supplies within the children’s department were seen to be in date with the exception of some simple use items such as gauze and a blood bottles. These items were removed when we brought them to the attention of staff.

At the last inspection a stair gate on the ward had been broken; we saw that this had been repaired.

**Assessing and responding to patient risk**

In the CQC Children and Young People’s Survey 2016 the trust scored 7.7 out of ten for the question ‘Were the different members of staff caring for and treating your child aware of their medical history?’ This was about the same as other trusts.

We requested data from the trust covering the number of staff trained in paediatric intermediate and advanced life support but this was not provided.

We requested the trust’s care of the deteriorating patient policy but it was not provided.

The department audited the treatment of children with suspected sepsis. Of the 14 areas of treatment in which quality was measured, the department scored ‘green’ which indicated good performance in eight, ‘yellow’ in five which indicated more work was needed and ‘orange’ in one area which indicated poor performance. The poorly performed area of treatment was the delivery of IV fluids. The department was working on raising awareness amongst staff of sepsis and reviewing the triage booklet in A&E.

In the CQC Children and Young People’s Survey 2016 the trust scored 9.6 out of ten for the question ‘Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?’ This was about the same as other trusts.

The department audited the use of the paediatric early warning score. Of the 90 charts reviewed, 69 were recorded as ‘well documented’. The most common problem with the remaining charts was no blood pressure documentation.

The trust had a clear escalation policy available on the intranet which covered the identification of capacity problems in paediatrics, actions to be taken in response and allocated responsibilities to staff.
CQC Children and Young People's Survey 2016 questions, safe domain, The Hillingdon Hospitals NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>How clean do you think the hospital room or ward was that your child was in?</td>
<td>0-15 adults</td>
<td>8.3</td>
<td>About the same as other trusts</td>
<td>S1</td>
</tr>
<tr>
<td>Were the different members of staff caring for and treating your child aware of their medical history?</td>
<td>0-15 adults</td>
<td>7.7</td>
<td>About the same as other trusts</td>
<td>S3</td>
</tr>
<tr>
<td>Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?</td>
<td>0-15 adults</td>
<td>9.6</td>
<td>About the same as other trusts</td>
<td>S4</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

The neonatal unit did not use the standardised template for recording the paediatric early warning score (PEWS) and instead used their own method of recording an assessment of the condition of babies. We saw that the department’s own chart recorded the same clinical observations including temperature, heart rate and blood pressure and were recorded appropriately.

Nurse staffing

Hillingdon Hospital reported their staffing numbers below for the period April 2017 to November 2017. Nursing staff reached 89% of planned capacity as at November 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Planned Staff</th>
<th>Number in post as at November 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Hillingdon Hospital</td>
<td>79.3</td>
<td>70.4</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From December 2016 to November 2017, the trust reported a vacancy rate of 10% in children’s services, compared to the trust’s overall vacancy target rate of 8%. (Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From December 2016 to November 2017, the trust reported a turnover rate of 19% in children’s services, compared to the trust target of 13%. (Source: Routine Provider Information Request (RPIR) P18 Turnover)

The neonatal unit was funded for 41.44 whole time equivalent (WTE) nurses with a 9.56 WTE vacancy rate.

Managers of the service we spoke with felt that the turnover rate reflected the career progression of staff as they developed at Hillingdon and went on to more senior roles. They felt that one of the main factors contributing to staff turnover was the location of the trust. Many staff moved to jobs in central London. All staff who left were offered an exit interview and confidential exit questionnaire. Managers we spoke with felt that no staff had left because they were unhappy.
From December 2016 to November 2017, the trust reported a sickness rate of 3% in children’s services for qualified nursing staff, compared to the trust target of 3%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Services for children and young people had 1,473 shifts filled by bank and agency staff which was the sixth highest core service uptake within the trust.

The trust did not provide accurate data for the total number of shifts overall and therefore we are unable to calculate the total number of shifts covered by bank and agency and the number of shifts left unfilled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

The paediatric department had capability to escalate five inpatient beds to care for high dependency unit (HDU) Level 1 patients. These are patients who needed intensive ward based care but did not require organ support. Level 1 HDU patients required one nurse to two patients. We observed on inspection and heard from staff that the nursing capacity required to staff these beds sometimes had an adverse effect on the nursing staffing across the ward, particularly at times where there was a high number and high acuity of patients on the ward. Managers of the service informed us that this had occurred four or five times through the winter.

**Medical staffing**

Hillingdon Hospital reported their staffing numbers below for the period April 2017 to November 2017. Medical staff reached an over-establishment of 6% of planned capacity as at November 2017. There was 24 hour consultant cover seven days a week. The trust had recently appointed seven new paediatric consultants in order to provide this level of cover.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Planned Staff</th>
<th>Number in post as at November 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hillingdon Hospital</td>
<td>43.4</td>
<td>45.8</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

There were paediatricians available to provide advice to all specialties in the hospital 7 days a week.

From December 2016 to November 2017, the trust reported a vacancy rate of 3% in children’s services for medical staff, compared to the trust’s overall vacancy target rate of 8%. (Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From December 2016 to November 2017, the trust reported a turnover rate of 6% in children’s services, compared to the trust target of 13%. (Source: Routine Provider Information Request (RPIR) P18 Turnover)
From December 2016 to November 2017, the trust reported a sickness rate of 0% in children’s services for medical staff, compared to the trust target of 3%. (Source: Routine Provider Information Request (RPIR) P19 Sickness)

The trust did not provide accurate data for the total number of shifts overall and therefore we are unable to calculate the total number of shifts covered by bank and locum and the number of shifts left unfilled. (Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

In September 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was the same.

Staffing skill mix for the 43 whole time equivalent staff working in children’s services at The Hillingdon Hospitals NHS Foundation Trust:

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>48%</td>
<td>40%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>0%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>45%</td>
<td>47%</td>
</tr>
<tr>
<td>Junior*</td>
<td>7%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

We saw consultants undertaking ward rounds which happened daily and there were daily consultant handovers. We observed a consultant handover and saw an inclusive, open discussion and good evidence of multidisciplinary team working.

Consultants used an online messaging group to organise shift cover and to alert colleagues to increases in demand. We observed this system put into use during our inspection when there was a sudden increase in patient numbers and acuity on the wards and saw that consultants responded quickly and arrived in the department to assist. Staff we spoke with told us consultants were very responsive to cover the wards.

Medical staff we spoke with told us that ward rotas were manageable and there were no problems with staffing levels.
Records
We found that the completion of records was good in paediatrics. We reviewed ten sets of care records and found that notes were legible and accurate and recorded relevant information about the care of children and young people. Notes were well organised and staff were able to access them. Patient notes used to record medical interventions were paper based and some patient information was accessed on the trust electronic intranet.

On two occasions during our inspection we observed that patient details including name, address and medical information were visible on unattended computers on the ward.

There were systems to flag on patient records when they had needs including a learning disability or where there were child protection concerns and staff we spoke with were aware of these flags.

Information governance training formed part of the mandatory training programme for staff and data provided by the trust showed that the paediatric department met the trust target of 95% of staff completing this training.

Medicines
We saw that medicines were stored appropriately and there were systems in place to ensure that patients received the right medications at the right time at the right dose.

Medications were recorded on patient records and we saw that these were clear, legible and accurate on the records we viewed. Allergies and patient details were clearly recorded.

We requested data covering the trust’s medications audit results for the year prior to the inspection but were not provided with this information for paediatrics.

Medicines were stored in dedicated medication fridges which had daily temperature checks. Temperature logs we looked at showed that the fridges had not exceeded the acceptable temperature limits and there were no recording gaps. Ambient room temperatures were also checked and logged and we saw that they did not exceed recommended levels.

Controlled drugs (CDs) are medications requiring additional security. Staff we spoke with were aware of the appropriate safety measures required and knew how to access medication policies on the trust intranet. There were lockable cupboards on each ward for keeping controlled drugs and keys were held by the nurse in charge.

Registers which recorded the stock of controlled drugs were stored in the cupboards. We noted that some stock was recorded in dedicated CD books but when these were filled up blank notebooks and diaries were used to record stock. We checked the stock levels indicated in the stock books and found them to be accurate. All medications we checked were in date.

Medicines to take out (TTOs) were stored securely until the patient was discharged. In one medication fridge we found medication such as a flu vaccine which the patient had not returned for. There was no documentation about why the patient had not come for the medication or whether this had been investigated. This medication was returned to the pharmacy to be
Incidents
Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2016 to November 2017, the trust reported no incidents classified as never events for children’s’ services. (Source: Strategic Executive Information System (STEIS))

Staff we spoke with had a good understanding of what would constitute an incident, including near misses, and how they would report one. The trust used an electronic incident reporting system and staff were able to show us how they would access it. Staff told us they were encouraged to report incidents and managers confirmed that they tried to encourage a “low threshold” for incidents. Staff told us they received feedback about incidents they had reported and could recall a recent serious incident where learning had been shared.

The department kept an incident log. There were 140 incidents from the reporting period of which two resulted in moderate harm, 54 were low harm and 84 resulted in no harm.

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in children’s services which met the reporting criteria set by NHS England from December 2016 to November 2017. The incident involved sub-optimal care of the deteriorating patient meeting SI criteria - Hickman line left unclamped and the bung was off. Significant blood loss leaving to shock with lactic acidosis. (Source: Strategic Executive Information System (STEIS)). There had been a significant response in the department to this serious incident including re-education for all staff.

There was a monthly patient safety newsletter which was sent to all staff and accessible on the trust intranet which safety information and feedback from incidents.

Safety thermometer
Staff we spoke with had a good understanding of what would constitute an incident, including near misses, and how they would report one. The trust used an electronic incident reporting system and staff were able to show us how they would access it. Staff told us they were encouraged to report incidents and managers confirmed that they tried to encourage a “low threshold” for incidents. Staff told us they received feedback about incidents they had reported and could recall a recent serious incident where learning had been shared.

The department kept an incident log. There were 140 incidents from the reporting period of which two resulted in moderate harm, 54 were low harm and 84 resulted in no harm.

The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. There had
been one incident where duty of candour had been applied and we saw evidence that this had been undertaken correctly and patients were kept informed. Most staff we spoke with had a good knowledge of duty of candour and could describe scenarios where it had been used.

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There was a monthly patient safety newsletter which was sent to all staff and accessible on the trust intranet which safety information and feedback from incidents.

Is the service effective?

Evidence-based care and treatment
The department delivered care in line with national clinical guidance and staff such as managers and practice development nurses reviewed practice and outcome data to improve the service in order to more effectively meet the needs of patients.

We reviewed a sample of trust policies including safeguarding and sepsis and found that they were comprehensive, in date and made appropriate reference to national guidance and best practice such as that recommended by the National Institute for Health and Care Excellence (NICE) and the Royal Colleges.

There was an extensive range of paediatric and neonatal protocols and guidelines as well as corporate policies and guidance on various clinical interventions on the trust intranet and staff showed us how they accessed them. Staff could also access paper copies on the wards.

There were processes to identify and implement new clinical guidelines including regular emails. The practice development nurse was responsible for ensuring care and treatment in the department was based on up to date evidence and clinical guidelines.

The department took part in a number of national audits and managers monitored results. We saw the department’s clinical audit log for the reporting period. Audits included, among others: epilepsy, IV antibiotics, transition in diabetes, education of new diabetes patients and urinary tract infections in children. The log included key concerns and actions identified.
Nutrition and hydration
There were processes in place to ensure that patients’ nutrition and hydration needs were met on the wards. The hospital dietitians attended paediatrics to support feeding and nutritional planning for children and young people.

Patient records we checked included nutrition and hydration assessments as part of care planning. There were special menus available for different patient groups including those who had specific dietary requirements such as allergies or intolerances.

There were protected meal times on the wards and we saw on inspection that these were respected by staff and visitors. This meant that non-urgent activities would stop and staff would support children and young people to eat their meals in necessary. We saw that children were positioned safely and supervised to eat their food.

We checked milk formula in the neonatal unit and found that it was sealed, within date and appropriately stored.

Pain relief
There was a pain management policy and staff we spoke with knew how to access it on the trust intranet. Staff told us that the hospital pain team were accessible and helped to review patients and provide advice and guidance.

There was a specialist adult pain nurse who supported the paediatric department and a multidisciplinary approach to pain management which included doctors, nurses and allied health professionals. Patients and those close to them we spoke with on inspection told us that their pain was managed effectively and staff were responsive to requests for additional pain relief.

Staff used appropriate tools to assess the pain of patients who were non-verbal such as the disability distress assessment tool (DisDAT). Care plans took account of pain management and were personalised to individual patients’ needs including cultural differences and manifestations of pain.

Patient outcomes
HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled over time. The NICE Quality Standard QS6 states “People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)”.

The data below shows that in the 2015/16 diabetes audit The Hillingdon Hospital performed worse the England average.

The proportion of patients receiving all key care processes annually was 51.6% which was significantly better than expected, compared to a national aggregate of 35.5%. The previous year’s score was 41.9%.
The average HbA1c value (adjusted by case-mix) at the trust was 73.5% which was significantly worse than expected, compared to a national aggregate of 68.3%. The previous year’s score showed a negative outlier.

The median HbA1c value recorded amongst the 2015/16 sample was 72.0, which was worse than the previous year’s median of 69.5 and showed a clinically significant decline.

(Source: National Paediatric Diabetes Audit 2015/16)

The data shows that from August 2016 to July 2017 no speciality at the trust had six or more readmissions of under ones readmitted following an elective admission and no speciality at the trust had six or more readmissions of patients aged 1-17 years old readmitted following an elective admission.

The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialties with the highest volume of readmissions. Only specialties with six or more readmissions are displayed.

The data shows that from August 2016 to July 2017 there was a lower percentage of under ones readmitted following an emergency admission compared to the England average and a lower percentage of patients aged 1-17 years old readmitted following an emergency admission compared to the England average.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

The trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>The Hillingdon Hospitals NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission rate</td>
<td>Discharges (n)</td>
<td>Readmissions (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>1.5%</td>
<td>871</td>
</tr>
<tr>
<td>No other specialty at the trust had six or more readmissions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty</th>
<th>The Hillingdon Hospitals NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission rate</td>
<td>Discharges (n)</td>
<td>Readmissions (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>1.9%</td>
<td>3,388</td>
</tr>
<tr>
<td>No other specialty at the trust had six or more readmissions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (September 2016 to August 2017)

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>The Hillingdon Hospitals NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
<td>Two or more admissions (n)</td>
</tr>
</tbody>
</table>

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### Asthma

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15.4%</td>
</tr>
<tr>
<td>1-17</td>
<td>9.4%</td>
<td>127</td>
<td>12</td>
<td></td>
<td>16.2%</td>
</tr>
</tbody>
</table>

### Diabetes

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Under 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>28.6%</td>
</tr>
<tr>
<td>1-17</td>
<td>*</td>
<td>28</td>
<td>*</td>
<td></td>
<td>12.9%</td>
</tr>
</tbody>
</table>

### Epilepsy

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
<td>31.5%</td>
</tr>
<tr>
<td>1-17</td>
<td>*</td>
<td>20</td>
<td>*</td>
<td></td>
<td>27.9%</td>
</tr>
</tbody>
</table>

Note - For reasons of confidentiality, numbers below six and their associated proportions have been removed and replaced with ‘*’.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

In the 2016 National Neonatal Audit, The Hillingdon Hospitals NHS Foundation Trust’s performance was as follows:

- **Asthma**
  - Under 1: 15.4%
  - 1-17: 16.2%

- **Diabetes**
  - Under 1: 28.6%
  - 1-17: 12.9%

- **Epilepsy**
  - Under 1: 31.5%
  - 1-17: 27.9%

- **Note**: For reasons of confidentiality, numbers below six and their associated proportions have been removed and replaced with ‘*’.

Do all babies < 1501g or a gestational age of < 32 weeks at birth undergo the first Retinopathy of Prematurity (ROP) screening in accordance with the current guideline recommendations?

There were 67 babies born with a birth weight < 1501g or with a gestational age at birth < 32 weeks who were assigned to the unit for ROP screening. 100% of these babies were screened on time in accordance with the NNAP extended screening window. This was above the national average, where 98% of eligible babies had their screening performed within the NNAP extended screening window.

Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?

There were 335 first episodes of care that were eligible for inclusion in this audit measure for the unit. Episodes of care lasting less than 12 hours have been excluded from analysis. The first consultation following admission occurred within 24 hours for 93% of the eligible episodes. This was above the national average, where 90% of eligible episodes had the first consultation within 24 hours of admission.

Are rates of normal survival at two years comparable in similar babies from similar neonatal units?

The results below include all of the infants that the unit is deemed to be responsible for entering follow up data for in 2016. It is recognised that not all eligible infants will have reached a suitable age for two year follow up until the audit year has finished. Results are updated each quarter to give units an indication of their progress towards completing the follow up data for these babies. Follow up data for these infants can be recorded at any neonatal unit, but the results for the infant will always be assigned to the unit of final neonatal discharge unit.

There were 28 babies born at < 30 weeks born between July 2013 and June 2014 who have been assigned to the hospital for two year health assessment based on their final neonatal discharge. Data was entered for 81% of the babies assigned to the unit, whilst nationally data was available for 61% of babies born at < 30 weeks born between July 2013 and June 2014.
What is the proportion of babies born <32 weeks who develop Bronchopulmonary Dysplasia?

There were 106 babies born < 32 weeks in your hospital who were included in the analysis for Bronchopulmonary Dysplasia. Of these babies 25 were identified as having Significant BPD.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

Clinical audit results and plans were discussed at regular clinical governance meetings in order to monitor issues and identify quality improvements. We saw minutes of these meetings.

Competent staff

From December 2016 to November 2017, 95% of staff within children’s services at Hillingdon Hospital had received an appraisal. The trust did not provide an appraisal target rate. Medical & Dental staff had the lowest completion rate of 67%.

A split by staff group can be seen in the graph below:

<table>
<thead>
<tr>
<th>AC - Services for children and young people</th>
<th>No. staff required (YTD)</th>
<th>No. staff who have received an appraisal (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>3</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>69</td>
<td>69</td>
<td>100%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>27</td>
<td>27</td>
<td>100%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>8</td>
<td>8</td>
<td>100%</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>21</td>
<td>14</td>
<td>67%</td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request P46)

Staff we spoke with told us that they found their appraisals useful for improving their work and plan development. Managers had regular informal catch ups with staff outside of their formal appraisals.

The trust also supported the continued professional development of staff including formal qualifications, training, conference attendance, mentoring and shadowing opportunities. There were opportunities for staff to further their careers at the trust including through transfers and promotion.

There was a supportive and encouraging environment for newly qualified staff in the department, student nurses told us they enjoyed working at the hospital and had many opportunities to learn.

Only 54% of nurses on the neonatal unit were qualified in specialty (QIS), this was below the level recommended by the British Association of Perinatal Medicine.
**Multidisciplinary working**

There was an effective multidisciplinary team (MDT) working environment in paediatrics at Hillingdon and staff we spoke with were positive about relationships between colleagues. We observed multidisciplinary approaches to care planning for patients and families.

Patient records we looked at showed that while it was clear who had overall responsibility for a patient’s care, there was input from a variety of disciplines including occupational therapists, play specialists, physiotherapists, dietitians and pharmacists.

There was a paediatric pharmacist available during office hours and a general pharmacist on call 7 days a week. There was play specialist and orthopaedic cover seven days a week.

There were daily MDT handover meetings which communicated important information about the list of patients. We observed one of these meetings and saw that there was a collaborative approach between clinical specialties with inclusive discussions about each child on the list.

There were good arrangements for young people transitioning between paediatric and adult care including MDT transition meetings. Paediatrics were flexible about treating young people up to aged 21 until they were ready to transition to adult care and there was continuing support once they transitioned.

In the CQC Children and Young People’s Survey 2016 the trust scored 8.8 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was about the same as other trusts. (Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Seven-day services**

There was a full paediatric inpatient service seven days a week with full paediatric consultant cover. The Neonatal Unit cared for premature or unwell babies seven days a week.

Paediatric operating theatres had lists five days a week, emergency cases would be seen in general theatres 24 hours per day, five days a week.

The children’s outpatients unit was open from 8:30am to 6pm, Monday to Friday and did not provide evening or weekend clinics. Managers of the service told us that they planned to extend services to run seven days a week but this depended on securing funding and adequate staffing.

Patients had input from allied health professionals such as therapists and pharmacists seven days a week.

**Health promotion**

We were told by managers of the service that responsibility for health promotion rested largely with the play specialist and they would speak to children and parents to promote areas such as healthy eating.
There were examples across paediatrics of staff supporting patients and those close to them to manage their own health. For example, specialist nurses with respiratory expertise in allergies provided teaching and support to patients.

There was a display board in the children’s outpatient waiting area with information about sugar in breakfast cereals and information leaflets on display.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Patients and those close to them who we spoke with told us that all staff explained procedures and sought their consent. All staff we spoke with understood the importance of involving patients in their care. Staff understood issues surrounding consent as well as relevant legislation such as the Mental Capacity Act.

Patient records we looked at showed evidence that consent had been gained prior to surgical procedures. We saw that it was signed and dated appropriately.

Staff knew how to refer patients to the trust safeguarding team if they were concerned about their capacity to make decisions. Staff we spoke with were aware of Fraser and Gillick competencies which help to assess whether children are mature enough to make decisions about their care.

Mental health patients were always accompanied by a mental health nurse as per the trust policy. The wards were not a designated place of safety and were not ligature free.

**CQC Children and Young People’s Survey 2016 Data**

The trust performed about the same as other trusts for all six questions relating to effectiveness in the CQC Children and Young People’s Survey 2016.

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you feel that staff looking after your child knew how to care for their individual or special needs?</td>
<td>0-15 adults</td>
<td>8.5</td>
<td>About the same as other trusts</td>
<td>E3</td>
</tr>
<tr>
<td>Did staff play with your child at all while they were in hospital?</td>
<td>0-7 adults</td>
<td>7.1</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>Did different staff give you conflicting information?</td>
<td>0-7 adults</td>
<td>7.3</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>Did the members of staff caring for your child work well together?</td>
<td>0-15 adults</td>
<td>8.8</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>During any operations or procedures, did staff play with your child or do anything to distract them?</td>
<td>0-15 adults</td>
<td>7.5</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>Did hospital staff play with you or do any activities with you while you were in hospital?</td>
<td>8-11 CYP</td>
<td>3.2</td>
<td>About the same as</td>
<td>E4</td>
</tr>
</tbody>
</table>
Is the service caring?

Compassionate care

Staff provided care and treatment in a compassionate way and treated patients with dignity and respect. We observed kind and helpful interactions between staff and patients. All of the children, parents and carers we spoke with on inspection were positive about the care received, one parent said “I know I can leave my son here and he will get exceptional care”.

Thank you cards and photos were displayed on the neonatal ward from children who had been cared for in the past on the unit.

There was good rapport between patients and staff and we observed nurses and doctors involving children well in their care and ensuring they were relaxed.

The trust participated in the NHS Friends and Family Test (FFT) with results on average very good for the paediatric department. The FFT response rate for the neonatal unit was 46% with an annual average score of 97% for the period of October 2016 to November 2017 where parents felt they would recommend the service.

There were paper FFT forms for patients and parents to fill in on the wards and collection boxes available. Staff told us that it was sometimes difficult to gather views this way as patients did not fill forms in until they were ready for discharge and by then they wanted to go home.

Children and young people had named nurses who they would see each time they attended and were able to see the same consultant, this information was displayed on their rooms.

The trust performed about the same as other trusts for all 10 questions relating to compassionate care in the CQC Children and Young People’s Survey 2016.

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults</td>
<td>8.7</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Did you have confidence and trust in the members of staff treating your child?</td>
<td>0-15 adults</td>
<td>9.0</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Were members of staff available when your child needed attention?</td>
<td>0-15 adults</td>
<td>8.4</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that the people looking after your child were friendly?</td>
<td>0-7 adults</td>
<td>8.8</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that your child was well looked after by the</td>
<td>0-7 adults</td>
<td>8.6</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)
hospital staff?

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you feel that you (the parent/carer) were well looked after by hospital staff?</td>
<td>0-15 adults</td>
<td>8.0</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Was it quiet enough for you to sleep when needed in the hospital?</td>
<td>8-15 CYP</td>
<td>6.6</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>If you had any worries, did a member of staff talk with you about them?</td>
<td>8-15 CYP</td>
<td>8.3</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that the people looking after you were friendly?</td>
<td>8-15 CYP</td>
<td>9.6</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Overall, how well do you think you were looked after in hospital?</td>
<td>8-15 CYP</td>
<td>9.0</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Emotional support**

The trust performed about the same as other trusts for all five questions relating to emotional support in the CQC Children and Young People’s Survey 2016.

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was your child given enough privacy when receiving care and treatment?</td>
<td>0-7 adults</td>
<td>8.9</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?</td>
<td>0-15 adults</td>
<td>8.3</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>Were you treated with dignity and respect by the people looking after your child?</td>
<td>0-7 adults</td>
<td>9.0</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>Were you given enough privacy when you were receiving care and treatment?</td>
<td>8-15 CYP</td>
<td>8.8</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>If you felt pain while you were at the hospital, do you think staff did everything they could to help you?</td>
<td>8-15 CYP</td>
<td>8.7</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

There was a psychologist available for children and young people with chronic long-term conditions and parents in the neonatal unit. Parents told us that emotional support was of good quality and readily available to them and their children when they needed it.
There were two dedicated play therapists who worked closely with doctors, nurses and other therapists to incorporate play into clinical interventions and care and support children and young people during their stay on the unit.

There was a hospital chaplain who visited children and young people to provide emotional support if they wished, or arranged for them to have access to someone appropriate to their faith. Children and young people could also visit the prayer room for a quiet space.

There were appropriate and supportive measures in place for children on end of life care at the hospital. The oncology team led on bereavement support. Palliative care patients were cared for on Peter Pan Ward which had larger cubicles which could accommodate family member staying with children. If children and young people decided to die at home, ward nurses liaised with community services provided in the borough by another trust to arrange the transfer of care. There was a multidisciplinary approach to end of life care with links to other specialist children’s acute services in London to ensure support for the child and family.

**Understanding and involvement of patients and those close to them**

We observed collaborative, patient-centred care and saw that staff worked with children and young people to promote their understanding and empower them to play an active role.

The parents and carers we spoke with told us that nurses and doctors involved their children well in discussions and explained things clearly in a way which was appropriate for their age. Patients and those close to them were kept informed about care plans, clinical interventions and referrals to other services and parents were involved in making decisions about care.

Throughout the inspection we saw that children and young people and their parents and carers were made to feel comfortable and informed by staff. Parents told us that the doctors explained treatment and procedures to their children clearly and we observed that this was the case.

The trust performed better than other trusts for one question, no score for one question and about the same as other trusts for the remaining 19 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016.

The question “Were you involved in decisions about your care and treatment?” scored better than other trusts and the question “If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?” had no score.

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did members of staff treating your child give you information about their care and treatment in a way that you could understand?</td>
<td>0-15 adults</td>
<td>9.0</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did members of staff treating your child communicate with them in a way that your child could understand?</td>
<td>0-7 adults</td>
<td>7.8</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did a member of staff agree a plan for your child’s care</td>
<td>0-15</td>
<td>9.4</td>
<td>About the</td>
<td>C2</td>
</tr>
<tr>
<td>Question</td>
<td>Category</td>
<td>0-15 adults</td>
<td>Description</td>
<td>C2</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>----------</td>
<td>-------------</td>
<td>-----------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Did staff involve you in decisions about your child’s care and treatment?</td>
<td></td>
<td>8.5</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>Were you given enough information to be involved in decisions about your child’s care and treatment?</td>
<td></td>
<td>8.6</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td></td>
<td>8.7</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>Were you able to ask staff any questions you had about your child’s care?</td>
<td></td>
<td>9.0</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>Before your child had any operations or procedures did a member of staff explain to you what would be done?</td>
<td></td>
<td>9.6</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>Before the operations or procedures, did a member of staff answer your questions in a way you could understand?</td>
<td></td>
<td>9.6</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td></td>
<td>8.7</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>When you left hospital, did you know what was going to happen next with your child’s care?</td>
<td></td>
<td>8.0</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>Do you feel that the people looking after your child listened to you?</td>
<td></td>
<td>8.5</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>Did hospital staff talk with you about how they were going to care for you?</td>
<td></td>
<td>9.3</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>When the hospital staff spoke with you, did you understand what they said?</td>
<td></td>
<td>8.8</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>Did you feel able to ask staff questions?</td>
<td></td>
<td>9.7</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>Did the hospital staff answer your questions?</td>
<td></td>
<td>9.7</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>Were you involved in decisions about your care and treatment?</td>
<td></td>
<td>7.2</td>
<td>Better than other trusts</td>
<td></td>
</tr>
<tr>
<td>If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?</td>
<td></td>
<td>No score</td>
<td>No score</td>
<td></td>
</tr>
<tr>
<td>Before the operations or procedures, did hospital staff explain to you what would be done?</td>
<td></td>
<td>9.8</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
</tbody>
</table>
Afterwards, did staff explain to you how the operations or procedures had gone?

| 8-15 CYP | 8.7 | About the same as other trusts | C2 |

When you left hospital, did you know what was going to happen next with your care?

| 8-15 CYP | 8.2 | About the same as other trusts | C2 |

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust planned and provided services in a way that met the needs of local people. The hospital delivered a broad range of services for children and young people, including a number of specialist paediatric services such as paediatric audiology, a diabetes team and a paediatric oncology shared care unit allowing children with cancer to be treated closer to home.

Peter Pan, the inpatient ward and Wendy ward, the children’s ambulatory ward covered a number of specialties such as oncology, haematology, orthopaedics, general surgical, general medicine, dental, ophthalmology and urology.

The hospital’s neonatal unit was a Level Two unit providing short term intensive care for premature babies (born from 27 weeks) as well as babies that were unwell. The unit had five intensive, three high dependency and twelve special care cots. Babies that required additional care and respiratory support were stabilised and transported to Level Three units in the locality. The community paediatric nursing team attended pre-discharge meetings and provided support to babies and their parents who had been discharged from the neonatal unit.

The four-bedded Paediatric Assessment Unit (PAU) located in the paediatric A&E was a short stay unit of up to 24 hours for children requiring observation or awaiting diagnostic results who did not need to be admitted to the ward. The PAU also accepted high dependency patients who were awaiting admission to the Peter Pan ward. For high dependency patients, cubicles closer to the nurse’s station were used. Children admitted to the PAU had to have been seen by a doctor from paediatric A&E or the urgent care centre or referred by a general practitioner through the telephone rapid access service provided by the children and young people’s service.

The children’s outpatients unit (Tinkerbell) catered for children aged 0-16 and provided a range of clinics including haematology, oncology, dermatology, endocrinology, diabetes, neurological, respiratory, allergy, dietetics, paediatric surgical and general paediatrics. The unit was open from 8:30 to 6pm Monday to Friday. The hospital had also implemented additional evening clinics to meet demand in allergy services. The trust delivered several specialist services such as a one-stop allergy clinic, diabetes and respiratory services and was also working towards providing comprehensive transition services. The service was in the process of implementing the Ready Steady Go programme to help patients prepare, plan and move from children’s to adult services.

The service worked with staff in schools to monitor asthma patients and had strong links with school nurses to refer to clinics if there were problems. The trust had also developed an asthma pathway nurse-led clinic across acute and community services which had reduced asthma
admissions. Paediatric integrated community clinics promoted GP learning and brought care closer to home.

The children and young people’s service actively engaged with children, young people, their parents and carers. Focus groups, patient and parent groups had been formed to develop new practices such as asthma clinics in the community, GP surgery and schools. There were also regular coffee mornings for parents of babies in the neonatal unit to share experiences. The diabetes team used text messages as a way of communicating with children and young people. The team also posted regular updates on a social media group page which patients could join.

The waiting room in Tinkerbell (children’s outpatients) was well resourced with toys for all ages and access to a range of information leaflets. However, while some adult outpatients areas had limited access to toys, we found that other adult outpatient areas (area C) where children had outpatient appointments had not been made child friendly.

Designated playrooms on Peter Pan and Wendy wards contained a variety of toys and games available for all ages. Peter Pan ward also had a ‘chill out’ room for older children which was furnished with comfortable chairs, a TV and games consoles. Wi-Fi was also available throughout the wards which children and families could use.

Patients over the age of 16 could choose whether they wanted to stay in the paediatric ward or move to an adult ward. The service worked closely with adult services when children chose to move to adult wards to ensure that there was a paediatric nurse on the ward at all times.

The paediatric matron had oversight of the service which children received in adult areas of the hospital and told us that there was good engagement throughout adult services in providing effective care for children.

The paediatric department also cared for high dependency level 1 patients on the Peter Pan inpatient ward. At the time of our inspection, senior leaders were negotiating for funding for high dependency unit (HDU) beds due to a year on year increase in high dependency patients. The service’s business plan recognised the challenges and priorities for the service including the need to commission level 1 critical care services in paediatric to meet the increase in higher acuity patients.

Staff had strong links with other agencies. A schoolteacher from the local education authority taught school age children who were admitted for five or more days in 30 minute sessions three times a week. There were links between community teams, health and social care agencies and mental health teams. We saw examples of this in children’s records and care plans. The paediatric community team provided outreach support for babies who were discharged from the neonatal unit and attended pre-discharge meetings at the hospital.

The trust performed about the same as other trusts for 16 questions, and no score for the remaining question relating to responsiveness in the CQC Children and Young People’s Survey 2016.

The question “Did the hospital give you a choice of admission dates?” had no score.
<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>For most of their stay in hospital what type of ward did your child stay on?</td>
<td>0-15 adults</td>
<td>9.9</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?</td>
<td>0-15 adults</td>
<td>8.8</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15 adults</td>
<td>7.7</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Were you able to prepare food in the hospital if you wanted to?</td>
<td>0-15 adults</td>
<td>4.1</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>How would you rate the facilities for parents or carers staying overnight?</td>
<td>0-15 adults</td>
<td>7.3</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Was the ward suitable for someone of your age?</td>
<td>12-15 CYP</td>
<td>8.2</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Were there enough things for your child to do in the hospital?</td>
<td>0-7 adults</td>
<td>7.5</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did your child like the hospital food provided?</td>
<td>0-7 adults</td>
<td>5.8</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did a staff member give you advice about caring for your child after you went home?</td>
<td>0-15 adults</td>
<td>8.7</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did a member of staff tell you who to talk to if you were worried about your child when you got home?</td>
<td>0-7 adults</td>
<td>8.1</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Were you given any written information (such as leaflets) about your child's condition or treatment to take home with you?</td>
<td>0-15 adults</td>
<td>7.9</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Were there enough things for you to do in the hospital?</td>
<td>8-15 CYP</td>
<td>6.6</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did you like the hospital food?</td>
<td>8-15 CYP</td>
<td>7.3</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did a member of staff tell you who to talk to if you were worried about anything when you got home?</td>
<td>8-15 CYP</td>
<td>8.6</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did a member of staff give you advice on how to look</td>
<td>8-15</td>
<td>9.0</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Question</td>
<td>CYP</td>
<td>Score</td>
<td>Other Trusts</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----------</td>
<td>----------------</td>
<td>---------------</td>
<td></td>
</tr>
<tr>
<td>Did the hospital give you a choice of admission dates?</td>
<td>0-7 adults</td>
<td>No Score</td>
<td>No Score</td>
<td>R3</td>
</tr>
<tr>
<td>Did the hospital change your child’s admission date at all?</td>
<td>0-7 adults</td>
<td>8.7</td>
<td>About the same as other trusts</td>
<td>R3</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Meeting people’s individual needs**

The service took account of the individual needs of children and young people including vulnerable patients and those with specific needs. The entrances leading to the children’s wards and children’s outpatients unit were decorated with cartoon characters to make the environment child friendly. Children’s wards were bright and welcoming and had been designed with children and young people in mind. There were colourful designs on walls on the wards including artwork created by patients. Patients also had personalised signs on cubicle doors and above beds which had their first name, their nurse’s name and what the patient liked.

There was a dedicated children’s garden and playground for patients and their siblings to use under supervision. The playground was wheelchair accessible and equipment had been adapted so that they could be used by children with disabilities.

Staff knew how to arrange translation services to support patients and their families whose first language was not English. Staff confirmed that it was easy to book translation services which could be arranged face to face, or by telephone. Staff also knew how to access British sign language services for children and young people with hearing impairments. Information leaflets on the ward could also be requested in large print or in seven different languages.

Children’s food menus were bright and colourful and options for specific cultures. For example, halal or kosher, could be chosen from the adults’ menu which was also made available. In response to feedback from patients, the service had worked with children to improve the menus. A patient’s parent said their child felt the food was good and they were always offered halal options. However some parents reported that there was a delay to see a dietitian.

There were set protected mealtimes but the service was flexible around the needs of the patients. Nurses told us they would make sandwiches or toast for children in the kitchen at any time. Children were also able to access snack boxes of sandwiches, fruit, juice and biscuits as well as milkshakes at any time of the day.

The hospital cared for children and young people with learning disabilities. Patients’ individual needs had been recorded in paper notes and on the electronic patient record. It identified the individual patient’s specific needs so that all clinical staff had immediate access to this information to help inform decision making to meet the needs of the individual. Staff were able to describe how they would support children with learning disabilities; however no formal training was provided. Input from the trust’s learning disabilities link nurse was available and the hospital also had strong
links with the Child Development Centre which was managed by another trust whose staff could come to support on the ward.

Parents and carers were able to use the kitchen on Peter Pan ward where there was a kettle, microwave and parents’ fridge. Parents and carers were also offered toast and a hot drink in the mornings. Chair-beds were available by bedsides and there were showers that parents could use on the ward. Accommodation was available on the neonatal ward as well as emergency accommodation for families whose child had been admitted in transit from the local airport. There was a family room on Peter Pan ward where families of oncology patients could stay with their child. The room had a DVD player and fridge. A quiet room on Wendy ward was available for sensitive conversations.

Psychological support for children with long-term conditions was available from a dedicated paediatric psychologist 5 days a week with out of hours psychiatric support from another trust. Parents in the neonatal unit had access to a psychologist on the unit.

The hospital’s play specialists worked closely with the multidisciplinary team and recorded development milestones through play sessions of up to an hour with children in their rooms or the playrooms. Playrooms on each ward were accessible to wheelchair users and contained toys for all ages including some multisensory equipment.

There was one play specialist on each ward providing support to patients five days a week with no weekend or evening provision. Play specialists supported children undergoing procedures on the ward by providing therapeutic play, distraction therapy and emotional support for older children. Play specialists reported that workload had increased with the increase in patients which put a strain on the amount of time that could be spent with each child. However comments from staff and parents about the play team were consistently positive and reflected that their input enhanced children’s hospital experience.

There were bays and cubicles for children on the wards and staff described how they would ensure that younger and older children were kept separate. A nurse described how they separated the bays and drew curtains to avoid mixed sex accommodation when the ward was particularly busy and explained the situation to both the patient and parent.

All staff we spoke with described how they would always make sure to record patient choice and to talk to the patient and not just their parents. A play specialist described helping a child with autism move to a cubicle room to help alleviate their anxieties.

Access to multi-faith chaplaincy was available and religious needs were recorded on the patient’s records; however staff were unsure about whether patients were being routinely made aware of this service.

There were no paediatric physiotherapists but the trust’s adult physiotherapists who had paediatric training provided physiotherapy to patients seven days a week. However there was no dedicated physiotherapy space in paediatrics.

There were effective processes in place to support vulnerable children and young people and the service had strong links with community services. Children who required child and adolescent
mental health services (CAMHS) were nursed on a one to one basis with a registered mental health nurse.

The ward operated ‘open access’ which meant that families of children with long-term conditions and cancer could call the ward directly for advice and support at any time of the day. A cubicle would be left vacant on the ward so a child could be admitted at any time. Children with long-term conditions who were known to the hospital had a priority access card, which allowed them to go straight to the paediatric assessment unit when they attended A&E.

**Access and flow**

There was timely access to children and young people’s services and most specialities were meeting referral to treatment (RTT) times. There was a good overall compliance of 95% for RTT at the hospital and there were no breaches of the 52 week referral to treatment limit. There was poor access to the epilepsy service due to low medical staffing to meet demand. Senior leaders were aware of this and MDT provision for paediatric epilepsy was included in the prioritised list of service developments for 2018/2019.

There were 129 transfers in the period March 2017 to February 2018. The trust had an escalation policy which was used to alert the team when there was high activity. All children attending would be seen and treated and an appropriate bed within the local area would be identified if there was none available on site. All transfers would be reviewed at morning handovers with learning points discussed.

The service was meeting the Royal College of Paediatrics and Child Health standards of consultant review within 14 hours of admission at 93% compliance. The children’s outpatients unit was also operating within the 18 week RTT standard.

Parents’ comments about the outpatients unit was mostly positive but some parents said that they would sometimes wait up to an hour after the initial appointment time and that appointment times for clinics meant they had to take their child out of school to attend these. Parents said they found the text and automated phone call appointment reminders useful.

The waiting time for blood tests had improved since our last inspection. Two phlebotomists had been employed and waiting times had improved significantly from a three month wait to three weeks.

The flow within children and young people’s services from admission, through theatres, wards and discharge was mostly managed effectively. We observed the patient journey through paediatric theatres and found that on the day of our inspection there was a delay in taking the patient to theatre due to an overrunning adult list. The paediatric patient was recovered in an adult area. Children and young people were transferred from the recovery area to the ward appropriately without delay; however a lengthy part of the journey was outside. This was mitigated with the use of blankets.

From April 2017 to March 2018, the average paediatric inpatient length of stay was recorded as 2.4 days, which was similar to other trusts for non-elective length of stay. Managers accounted for the increase in length of stay due to an increase in patient acuity. To reduce length of stay, the
service had introduced the Paediatric Assessment Unit which helped to improve Paediatric A&E performance and allow for a short stay pathway for selected patients who were suitable for early discharge.

General practitioners assessing or treating children with unscheduled care needs had access to 24/7 immediate telephone and email advice from a consultant paediatrician. The service provided a rapid access service so that a child could be referred to the paediatric assessment unit. Urgent next day clinics were also available on Wendy ward. Senior leaders commented that this service had reduced admissions from 33 to 3 over the past year.

The Paediatric Assessment Unit (PAU) had improved the flow of patients from paediatric A&E to the ward and ensured that patients who did not need to be admitted could be monitored over 24 hours on the unit. However, staff on the PAU commented that high dependency patients would sometimes be admitted to the PAU while a bed and staff was being organised on the ward which put pressure on the staffing in paediatric A&E.

Referral protocols were available on the trust intranet and included internal and external referral processes for different services including safeguarding, social services, mental health, GP and community services. Staff found these easy to access and felt supported by the community paediatric service which operated seven days a week.

Staff told us the CAMHS service was easy to access but sometimes took longer to arrange out of hours.

Paediatric bed management meetings happened daily on the ward led by the matron. These meetings reviewed bed occupancy levels and planned to improve access and flow through the department by transferring and discharging patients where appropriate.

From November 2016 to October 2017, the trust saw neonatal bed occupancy fluctuating between 20-60% which was below the England average, with the exception on of September 2017 where this was the same as the England average.

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month. *(Source: NHS England)*

The ‘did not attend’ (DNA) rate for first appointments in children’s paediatric outpatients averaged 15% and 20% for follow-ups. The total DNA rate was 11.3%. Senior leaders were aware of this and had implemented a text reminder system and an automated phone call the week before and the day before an appointment. If children continually did not attend clinics, the safeguarding team would also be notified.
Senior leaders told us that the implementation of school clinics for children with diabetes had greatly improved the DNA rate of this group of patients as they did not need to worry about the stigma of missing school.

**Learning from complaints and concerns**

From November 2016 to November 2017 there was one complaint about children’s services which the trust took 30 days to investigate and close. This was in line with the trust’s complaints policy, which stated complaints should be completed within 30 days.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, however we did not see evidence that learning was shared with staff. Feedback from patients and relatives was made through Friends and Family Test comment cards which were available on the wards and outpatients unit. These comment cards were brightly coloured and child friendly with icons to help children choose what best described their hospital experience.

Children and their families could speak directly with staff if they wanted to complain. Formal complaints were made through the Patient Advice and Liaison Service and there were leaflets and posters on the wards signposting the service. The matron addressed informal complaints as they arose by speaking with patients and families directly and explaining how they would address their concerns and follow up with them. Families and carers said they felt confident that any complaints they made would be taken seriously and acted upon.

The service had listened to complaints about the food on the ward and had taken action by involving children in tasting sessions and changing catering contractors. Some children had complained about not liking food touching other food on the plate and the catering team had rectified this by ensuring food could be put into small pots within the plate so they did not touch.

**Is the service well-led?**

**Leadership**

Paediatrics was within the Women’s and Children’s clinical division and was managed by a paediatric manager who was also the matron. There was also a clinical lead, service manager and neonatal manager running the service. The division as a whole was managed by a divisional director, assistant director of operations and an assistant director of nursing. There was an established and stable leadership team.

Staff told us that they thought the leadership of the department were visible, approachable and supportive and that the department was well led. Staff told us that managers had a good understanding of what was happening at ward level. Staff told us and we corroborated from our interviews with managers that they had an understanding of the challenges facing the department and plans to meet these challenges.

Staff we spoke with told us that senior leaders of the trust sometimes visited the wards. Staff told us they felt confident raising issues and concerns both with their immediate managers and senior leadership.
Consultant doctors told us they had good access to clinical leaders in the department and had their concerns heard at leadership level.

Leaders of the paediatric service felt that they had a voice at board level and that the hospital as a whole was committed to services for children and engaged with them in areas such as transition arrangements.

**Vision and strategy**
The trust vision was “to be an outstanding provider of healthcare through leading health and academic partnerships, transforming services to provide better care when needed”. This was underpinned by the trust CARES values which stood for communication, attitude, responsibility, equity and safety.

The values were developed with patients and described the behaviours they and the trust expected from staff. Staff we spoke with knew and understood the trust vision and values and had a sense of their roles in exhibiting the values in their work.

The service was developing their paediatric high dependency unit (HDU) beds and planned to formulate an HDU team which could be deployed to follow patients requiring level 2 care through the hospital.

**Culture**
The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. There had been one incident where duty of candour had been applied and we saw evidence that this had been undertaken correctly and patients were kept informed. Most staff we spoke with had a good knowledge of duty of candour and could describe scenarios where it had been used.

We found a positive and inclusive working culture within the children and young people’s services at Hillingdon, all clinical staff we spoke to were passionate about achieving the best for patients and staff we proud to work for the trust. Staff we spoke with described a supportive and child-focussed environment and said they felt supported and valued by their managers.

There was a “can do” attitude amongst both managers and clinical staff towards meeting challenges and improving the service for the future. Leaders of the service were proud of their staff and highlighted their efforts and contribution to the department and high standard of care for patients. Managers told us that there was a high rate of staff returning to work at Hillingdon who had previous left to work elsewhere and they felt that this was indicative of the positive working culture at Hillingdon.

Nurses we spoke with told us there was a supportive, respectful and positive working atmosphere and that there were good relationships with colleagues from different disciplines and levels of seniority.
Managers of the service were able to give examples of where action had been taken to address staff behaviour not in line with trust values. Conflict was resolved constructively. Staff we spoke with felt that they were treated fairly by managers.

Consultant doctors told us there was a supportive culture among clinicians and an open approach to challenge and peer review.

The trust made use of ‘Greatix’ for staff to report and share when their colleagues had gone above and beyond, staff we spoke with were positive about this feature and used it regularly.

**Governance**

There were effective governance structures in place in the paediatric department with clear lines of responsibility. There were regular staff meetings which provided a forum for staff to share their views or concerns with managers. Staff and managers we spoke with felt that governance structures were effective.

There were quarterly clinical governance meetings which all staff we invited to attend. There were weekly meetings where cases were reviewed and lessons learned.

Governance and performance information was shared with staff in a monthly newsletter available via the trust intranet.

**Management of risk, issues and performance**

The service kept a risk register which was reviewed regularly with the trust risk facilitator and discussed at monthly governance meetings.

Risks to the service had been taken into account in planning and delivery. For instance, the department had had a comprehensive winter pressures plan which we heard had worked well, although there had been considerable pressure on the service in patients numbers and acuity.

The issues and risks which managers identified were in line with what we found on inspection and there was alignment between these and the risks outlined on the risk register.

There were business continuity plans which set out the procedure for ensuring that the department could continue to provide care in various circumstances which could interrupt the service.

**Information management**

There were computer stations throughout the paediatric areas with access to the trust intranet, staff told us there were a sufficient number of these computers for them to access information when they needed it.

The department used a combination of paper and electronic patient records. We saw that notes throughout the department were well organised and stored securely in dedicated trolleys. On two occasions during our inspection patient information name, address and medical details was left on display and unattended on computers in the department.
On wards there were clearly labelled drawers and shelves for access to forms and records.

**Engagement**

Managers of the service told us that public engagement was limited to gathering and analysing responses to the Friends and Family Test (FFT). They told us they would like to develop more mechanisms for engaging with groups such as patient forums but that it was difficult to get patient engagement in this.

Managers and staff told us they thought that paediatrics was well represented throughout the trust and there was good communication from trust managers. There was regular trust and departmental communication through newsletters, staff emails and regular team meetings. Staff told us they felt clear about plans for the trust.

There were examples where the service had been designed with input from patients. For instance, the service manager had taken a group of patients to a meeting with a prospective new catering supplier to try the food and have input into the menu.

The service manager described a positive working relationship with the local Clinical Commissioning Group (CCG). There were regular meetings with the CCG and collaborative working on areas such as transitional and community clinics.

**Learning, continuous improvement and innovation**

The service had implemented a medical staffing model of 24 hour paediatric consultant cover seven days a week which had recently involved securing funding for the recruitment of seven new consultants.
End of life care

Facts and data about this service

The trust provides end of life care (EOLC) at The Hillingdon Hospital (THH). EOLC encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust and also in the community. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust has a multidisciplinary specialist palliative care team (SPCT) that consists of three palliative consultants and four whole time equivalent (WTE) clinical nurse specialists (CNSs). The trust had an integrated approach to working with patients at the end of their life, therefore there were no allocated beds or wards for end of life care patients. Instead, patients at the end of life were cared for on medical wards. The SPCT also supports ward staff to deliver care to patients at the end of their life.

The SPCT delivers face-to-face CNS and consultant cover in the trust Monday to Friday, 9am to 5pm. The service does not operate on the weekends. Out of hours, advice is provided by the local hospice via telephone.

From October 2016 to September 2017 the trust had 782 deaths.

The trust is part of the London EOLC clinical network and is also a member of the Royal Marsden Partners Cancer Vanguard. Local partners include the Mount Vernon Cancer Centre, the Michael Sobell House Specialist Palliative Care Centre, and the Harlington Hospice.

A bereavement team provides support to relatives from Monday to Friday, 9am to 12pm. There is a chaplaincy service available to patients, relatives and staff, seven days a week. THH has its own Macmillan Information Centre on site.

We previously inspected the service in October 2014. Concerns identified during this inspection included a lack of side rooms for private conversations to be held, no end of life care strategy and limited governance systems in place. Also, the completion of ‘do not attempt cardio pulmonary resuscitation’ (DNACPR) forms was variable and the documentation of mental capacity assessments was inconsistent.

We completed an announced inspection of the end of life care service on 6, 7 and 8 March 2018. We visited nine wards, including medical and surgical wards, the emergency department, the acute medical unit (AMU) and the critical care ward. We visited the mortuary, the bereavement team and the multi-faith room. We spoke with three patients and four relatives. We spoke with all members of the SPCT team and over 20 members of the wider staff including medical and nursing staff, portering service staff and mortuary and chaplaincy staff. We reviewed 10 patient care records, 15 DNACPR forms and six medication charts.

Is the service safe?
Mandatory training

The trust set a target of between 80-95% for completion of mandatory training and their overall training compliance for end of life care (EOLC) staff was 87% against this target. Staff received mandatory training on a rolling annual programme which was provided through a mix of classroom based sessions and e-learning.

A breakdown of compliance for mandatory courses from April 2017 to November 2017 for all staff in end of life care at Hillingdon Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained (YTD)</th>
<th>Number eligible (YTD)</th>
<th>Completion (%) YTD</th>
<th>Target Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Transfusion</td>
<td>80%</td>
<td>14</td>
<td>14</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>90%</td>
<td>14</td>
<td>14</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>80%</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>90%</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>80%</td>
<td>16</td>
<td>17</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 3 years</td>
<td>80%</td>
<td>9</td>
<td>10</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>80%</td>
<td>15</td>
<td>17</td>
<td>88%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>80%</td>
<td>7</td>
<td>8</td>
<td>88%</td>
<td>Yes</td>
</tr>
<tr>
<td>Corporate Induction</td>
<td>80%</td>
<td>6</td>
<td>7</td>
<td>86%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>80%</td>
<td>14</td>
<td>17</td>
<td>82%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>13</td>
<td>17</td>
<td>76%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>80%</td>
<td>12</td>
<td>17</td>
<td>71%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>80%</td>
<td>6</td>
<td>9</td>
<td>67%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>136</strong></td>
<td><strong>157</strong></td>
<td></td>
<td><strong>87%</strong></td>
<td></td>
</tr>
</tbody>
</table>

10 out of 13 mandatory training modules met the trust target. ‘Manual handling – object training module’ had the lowest completion rate of 67%, compared to the trust target of 80%.

Safeguarding

Staff informed us that they had up-to-date safeguarding policies available to them on the hospital intranet. Staff showed an awareness of safeguarding procedures and knew the signs to look for if they were concerned that a patient was at risk of or had been exposed to abuse. Staff reported safeguarding concerns to the wider safeguarding team and would follow these up regularly.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.
In the year prior to our inspection there were no safeguarding referrals specifically for patients at the end of life. If a patient was recognised as being at risk of harm, the staff would inform the wider safeguarding team in order to mitigate risk.

**Safeguarding training completion rates**

All Specialist Palliative Care Team (SPCT) staff were trained in safeguarding level 2 in both adults and children.

The trust set targets between 80-90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April 2017 to November 2017 for all staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained (YTD)</th>
<th>Number eligible (YTD)</th>
<th>Completion (%) YTD</th>
<th>Target Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>90%</td>
<td>14</td>
<td>14</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>80%</td>
<td>16</td>
<td>17</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>90%</td>
<td>16</td>
<td>17</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>46</td>
<td>48</td>
<td>96%</td>
<td></td>
</tr>
</tbody>
</table>

All three safeguarding modules met the trust target.¹

**Cleanliness, infection control and hygiene**

There were clear protocols for the staff to follow for cleaning the premises and equipment and the trust had an infection prevention and control (IPC) policy. Cleaning schedules were in place and there were clearly defined roles and responsibilities for cleaning and decontaminating equipment, and for cleaning the environment. We observed SPCT staff wearing the appropriate clothing and following infection control protocols, for example, when entering or leaving a patient bedside. We saw evidence of SPCT staff washing their hands before and after patient contact and staff adhered to the bare below the elbow (BBE) dress code. Between April and June 2017, hand washing audits revealed 90% to 97% compliance across both surgical and medical wards. In the same reporting period BBE audits revealed between 96% and 99% compliance across both surgical and medical wards.

Ward staff performed last offices and completed mortuary paperwork to accompany deceased patients to the mortuary. This paperwork included a section on any infectious conditions that mortuary staff needed to be aware of. The porters would then collect the body and take it to the mortuary. Appropriate procedures were followed in the event of death to identify and protect staff from infectious disease. Standard IPC precautions were adopted by staff at all times, as per trust policy. Death notification paperwork was completed by nursing and medical staff to evidence this, before a body could be removed from the place of death. Copies of these forms accompanied the body and the use of discrete labels to indicate infection was recommended where necessary. Although the porters did not have need for increased IPC training they were aware of this process and followed guidelines. All porters had basic infection prevention and control training.

¹ (*Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training*)
The mortuary was visibly clean and well maintained. We observed daily cleaning checklists completed by staff and the same member of staff cleaned the mortuary daily. Domestic staff cleaned the main areas of the mortuary but mortuary staff cleaned the fridges and post mortuary room. The mortuary staff were responsible for the deep cleaning of fridges which occurred every six months. Cleaning logs for this were also completed routinely and in a timely manner.

On the wards, we observed safe systems for managing clinical waste. All sharps bins we observed were used adequately and not overfilled. Staff used these bins appropriately. All staff we observed followed the trust infection control guidelines and were observed using alcohol gel and adhering to the policy of BBE.

Non-clinical areas we visited, such as the bereavement centre and the chapel areas, were visibly clean and well maintained. We observed staff following infection control guidance and observing the trust policy of being BBE.

Environment and equipment
The trust used T34 syringe pumps for delivering measured doses of pain medication. These conformed to national safety guidelines on the use of continuous subcutaneous infusions of analgesia (pain relief medication delivered via a needle or soft cannula under the skin).

At our previous inspection we found that there were systems in place to ensure patients using a syringe pump to administer analgesia were sent home with the equipment but some patients did still go home with them. The service had taken action to streamline this process by purchasing 28 new T34 syringe pumps for the administration of measured doses of pain medication. The service worked well with the community team to ensure that if a patient were to leave the trust, their syringe pump would be replaced with a transition pump managed by the community team.

The administration team that worked with the SPCT would make a note of where the syringe pumps were in order to avoid any being taken out of the trust. As end of life and palliative patients could stay on any medical ward, all wards were staffed with a medical devices coordinator who provided training to staff if a patient required a syringe pump. SPCT staff informed us that this worked well.

At the time of our inspection there was only one patient on a syringe pump. We found this was well maintained and staff knew who to contact if they had any concerns relating to the syringe pump.

The body store had capacity for 49 bodies. The fridges consisted of a number of labelled compartment bays, each containing racks for holding the body trays upon which bodies were stored. There were eight large and four extra-large bays to accommodate bariatric patients. At the time of our inspection, the number of deaths was unusually high and the mortuary was therefore equipped with nine additional temporary bays. These bays were being used in the viewing area which was not in use because of this at the time of our inspection.

There was an automated system to measure the temperature of fridges in the mortuary. If a fridge temperature went out of normal range, it would send an alarm to the estates team. The fridge

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2 Please note, no post mortems took place on site.
alarms were tested monthly. We reviewed the last six months of logs and found them to be fully complete. There was CCTV in the mortuary and guests had to complete an entry in the sign-in book in order to enter.

Assessing and responding to patient risk
At our last inspection of the service we found a mixed response from nursing staff across the wards in understanding how to identify a patient was dying and what support to offer. The service had taken action to ensure that more staff across the wards had a better understanding of end of life care. The SPCT had done a significant amount of work on the two ‘showcase’ wards, namely, Hayes ward and Grange ward. These wards had been refurbished and showcased the new working method to focus on end of life care. The staff on these wards had been trained in end of life care and the staff we spoke to were aware of the processes of identifying and treating a patient at the end of their life. All wards had access to the SPCT contact details and all staff we spoke with were confident that they could identify and treat a patient at the end of their lives.

When a patient was identified as being at the end of their life, a comprehensive risk assessment was carried out. We saw evidence that most initial assessments were completed within 24 hours. Staff could ask the SPCT for assistance, but there were clear guidelines around the risk assessments needed for end of life patients. A symptom observation chart was used to assess care needs. This included scoring patients for pain, agitation, breathlessness, respiratory secretions, dry mouth, nausea and vomiting. Staff we spoke with informed us that the symptom observation chart was “very useful” and that they used it alongside the national early warning score (NEWS) to ensure that patients at the end of their life were monitored adequately. We observed in records that patients at the end of their lives had assessments completed within 24 hours. These records contained risk assessment tools in skin integrity, nutrition and falls risk. We observed risk assessment in relation to nutrition and hydration, falls, the use of bed rails, pressure sores and general skin integrity.

We observed a multi-disciplinary team meeting (MDT), which identified patients’ end of life care needs. We found that the rationale behind the discussions in the MDT were clearly documented in the patient records. On both Hayes and Grange wards, we found that there were resources to support both staff and patients through the transition to end of life care. On other wards, staff had access to end of life care resources and informed us that they regularly used them.

Staff across the wards identified and responded appropriately to the changing risks to patients and were supported to do so by the SPCT. This helped ensure patients were kept safe. Across the service, contingency business plans were in place in case of an emergency. Staff had an awareness of what actions to take in the event of a major incident, including a fire or a clinical emergency and 88% of staff were trained in fire safety.

Nurse staffing
The Hillingdon Hospital have reported their staffing numbers below for the period April 2017 to November 2017. Nursing staff reached 83% of planned capacity at the time of our inspection.³

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Planned Staff</th>
<th>Number in post as at November</th>
</tr>
</thead>
</table>

³ (Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)
From December 2016 to November 2017, Hillingdon Hospital reported a turnover rate of 0% in end of life care, compared to a trust target of 13%.\(^4\)

From December 2016 to November 2017, Hillingdon Hospital reported a sickness rate of 1% in end of life care, compared to a trust target of 3%.\(^5\)

There was no bank usage or unfilled shifts in the reporting period.

All the nurses on the SPCT were clinical nurse specialists. There was no end of life champion on each ward.

### Medical staffing

The Hillingdon Hospital have reported their staffing numbers below for the period April 2017 to November 2017. Medical staff had an over-establishment of 17% of planned capacity as at November 2017.\(^6\)

The SPCT had three consultants at the time of our inspection. One consultant was whole time equivalent.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Planned Staff</th>
<th>Number in post as at November 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hillingdon Hospital</td>
<td>3.6</td>
<td>4.2</td>
</tr>
</tbody>
</table>

From December 2016 to November 2017, Hillingdon Hospital reported a turnover rate of 0% in end of life care, compared to a trust target of 13%.\(^7\)

From December 2016 to November 2017, Hillingdon Hospital reported a sickness rate of 0% in end of life care, compared to a trust target of 3%.\(^8\)

The service met the National Guidance for Specialist Palliative Care, helping to deliver commissioning objectives (December 2012). This guidance states that for every 250,000 people, the minimum requirement was two whole time equivalent (WTE) consultants in palliative medicine.

We did not observe any evidence that the safety of care delivered by the SPCT had been impacted by staffing. The service maintained agreements with a hospice that had a 24-hour on-call consultant that could be reached by telephone. All the staff we spoke with throughout the wards were aware of the number to contact should they require out-of-hours speciality advice.

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\(^4\) (Source: Routine Provider Information Request (RPIR) P18 Turnover)  
\(^5\) (Source: Routine Provider Information Request (RPIR) P19 Sickness)  
\(^6\) (Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)  
\(^7\) (Source: Routine Provider Information Request (RPIR) P18 Turnover)  
\(^8\) (Source: Routine Provider Information Request (RPIR) P19 Sickness)
**Records**
Staff kept appropriate records of patient care and treatment.

At the time of our last inspection we found that there was no specific care plans for end of life care. The service had made improvements in terms of end of life care planning. Staff had access to an up-to-date advanced care planning web-based register and to patients’ paper medical records. Patients receiving end of life care had an individualised plan, which included the holistic assessment of physical, spiritual and psychological needs. The service had introduced a symptoms observation chart for palliative patients. This chart sat with the routine national early warning scores (NEWS) and tracked the following: patient pain, agitation/distress, breathlessness, respiratory secretions, dry mouth, nausea and vomiting. The nursing staff on the wards informed us that the symptom observation chart was very helpful in addressing the needs of palliative patients.

Over the course of the inspection we reviewed 10 patient care records and found they were legible, signed and dated. Patients receiving end of life care had an individualised care plan, which included holistic assessment of physical, spiritual and psychological needs. This meant that staff were following National Institute of Health Care Excellence (NICE) guidance with reference to the use of a specific end of life individualised care record.

We reviewed 15 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. All were completed by middle grade doctors and countersigned by a consultant. All but two of the DNACPRs contained evidence that the reasons for the decision were discussed with relatives. In one case, the DNACPR was illegible. Overall, the completion of DNACPR forms had improved since our last inspection.

Patients information was shared with other services on discharge. SPCT staff informed us that discharge summaries were completed and sent to GPs when the patient was discharged. These summaries contained information about the patients medicine, condition, treatment and if their end of life status. The service also worked well with community teams to ensure a seamless transition into community care if required.

**Medicines**
The service prescribed, administered and stored medicines well.

Staff prescribed anticipatory medicines for patients receiving end of life care. Anticipatory medicines are medicines prescribed for use on an ‘as required’ basis to manage common symptoms that can occur at the end of life. Guidance on the use and prescription of anticipatory medicines included advice for staff on which medicines to prescribe to manage common symptoms such as pain, agitation and respiratory secretions.

The one patient on a syringe pump at the time of our inspection had clear and concise medication records. The syringe pump chart sat in a separate chart to the main medication records.

Over the course of the inspection we looked at six prescription and medication records. We noted that all were written in legible handwriting and documented patient allergy status, as well as
medicines reconciliation. Medicine reconciliation is the process whereby the patients’ current medications are reviewed to ensure the most up-to-date prescriptions are used. Records were clear and fully completed in most cases. They showed people were usually given their medicines when they needed them and any reasons for not giving people their medicines were recorded.

**Incidents**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From December 2016 to November 2017, the trust reported no incidents classified as never events within end of life care\(^9\).

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from December 2016 to November 2017\(^{10}\).

All staff we spoke with, including clinical staff, mortuary and bereavement staff and administrative staff knew how to report incidents via the trust’s electronic reporting system. Staff at all levels confirmed their understanding of the importance of being open when/if something went wrong and their responsibilities under the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. In the 12 months prior to our inspection the service had not had any duty of candour incidents.

**Safety thermometer**

The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are ‘harm free’ during their working day. This is not limited to hospital; patients can experience harm at any point in a care pathway and the NHS Safety Thermometer helps teams in a wide range of settings, from acute wards to a patient’s own home, to measure, assess, learn and improve the safety of the care they provide.

The service was not able to provide data safety thermometer data for patients on an end of life pathway as these patients did not sit on any specific ward. For more information, please see the medicine report.

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\(^9\)(Source: NHS Improvement - STEIS (December 2016 – November 2017))
\(^{10}\)(Source: Strategic Executive Information System (STEIS))
Is the service effective?

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and reviewed evidence of its effectiveness. Documentation used to provide end of life care was based upon national guidance for best practice, including the “Five Priorities of Care”. These priorities recognised the dying person, and those identified as important to them should be involved in decisions about treatment and care and are set out by the Leadership Alliance for the Care of Dying People. Also, the 2018 End of Life Care Strategy referenced Department of Health and National Institute for Health and Clinical Excellence (NICE) guidelines were also used. Policies and guidance were accessible both electronically and in resource packs put together by the SPCT.

Staff on the wards were aware of the SPCT and spoke positively of the assistance the team offered. Staff informed us of the process they took if they wanted to refer a patient to the SPCT. The service had a tag system that would flag their patients if they were admitted in any other part of the service.

In the year prior to our inspection there were 827 deaths reported in the service. In the year prior to our inspection, the service saw 934 patients referred to the palliative care service. Of these patients, the SPCT had input in 44% of cases as these cases were complex enough to warrant specialist input. Of these referred patients, 91% of patients were seen within 24 hours of referral.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and were aware of the GMC guidance for supporting nutrition and hydration in end of life care patients. They used special feeding and hydration techniques when necessary.

The service used the Malnutrition Universal Screening Tool (MUST) for all patients. Nutrition and hydration requirements were clearly recorded in patient notes within the patients’ medical records. We saw evidence that patients received care from dietitians regarding swallowing assessments. This enabled food and drink to be given where appropriate in the last days of life. In the majority of records we checked we observed speech and language input where necessary.

On the wards, red trays at meal times were used to alert nursing staff the patient may require extra help. Protected mealtimes were in force, to ensure patients felt comfortable and safe to be able to eat their meals without any interruptions.

**Pain relief**

Staff considered adequate pain relief for end of life care patients to be a priority and where needed, they sought guidance and input from the specialist palliative care team (SPCT).

Staff we spoke with demonstrated an awareness of symptom control and the use of anticipatory medicines. Anticipatory medicines are medicines prescribed for use on an ‘as required’ basis to manage common symptoms that can occur at the end of life. We checked the prescription records for patients on anticipatory medicines and found that the frequency for prescription of opioids was not noted down in any records. Although this is not best practice as a non-specialist member of
staff may not know the frequency at which to administer anticipatory medicines, this is not unusual.

Nursing staff across the trust used the numeric rating scale (NRS), with patients asked to score their pain from zero to 10. In this scale, zero meant no pain and 10 was extreme pain. An adapted pain scoring tool was available for those who did not speak English, or had communication difficulties.

Drugs were administered by a syringe pump where the oral route had become inappropriate. Staff did not rely on the SPCT to set up a syringe pump if a patient required one. There were syringe pump champions on each ward who were trained in the set up and maintenance of syringe pumps. These champions also offered ad-hoc training when and if staff requested.

Patient outcomes

End of life care Audit: Dying in Hospital

The trust participated in the end of life care audit: dying in hospital 2016 and performed better than the England average for four of the five clinical indicators. The one indicator that failed to meet the England average was “Is there documented evidence in the last 24 hours of life of a holistic assessment of the patient’s needs regarding an individual plan of care?” scoring 36% compared to a national average of 66%. In all the records we observed we saw that staff had improved on this measure.

The trust answered ‘no’ to four of the eight organisational indicators, including “Was there face-to-face access to specialist palliative care for at least 9am to 5pm, Monday to Sunday?” At the time of our inspection, the SPCT operated between 9am to 5pm, Monday to Friday. The service did not operate on weekends but did ensure plans were in place for both staff and patients who had any questions or concerns outside of their working hours. For example, all palliative patient records had the contact numbers for out of hours advice and all wards had resource folders with information specifically for palliative patients that the SPCT had produced.

The mortuary staff had their own annual audit calendar that included auditing the patient journey, the completion of the mortuary register and the condition of the deceased on arrival in mortuary. In an audit of the deceased patient journey completed in November 2017, it was found that all standard operating procedures were followed correctly and all equipment was used safely. In a September audit of patient length of stay in ward after death, it was found that 77% of patients were collected within four hours. This was an improvement on the previous year’s audit findings, when only 31% of patients were collected within four hours of death.

We observed that both the special palliative care team and EOLC/dementia team attended Gold Standard Framework (GSF) meetings with GP practices in their localities. GSF meetings are multidisciplinary meetings that focus on the needs of patients at the end of life and aim to improve coordination and quality of care.

Competent staff

At the time of our last inspection, the end of life training schedule had been put on hold and not all staff had been trained in end of life care. At the time of this inspection, 78 members of staff across
the two showcase wards had been trained in end of life care. The SPCT also provided ad-hoc ward based training and were due to launch the end of life care induction for new doctors and nurses. The SPCT team were included in both the nursing and junior doctor induction programme. This ensured that all new nursing and clinical staff had an awareness of the role of the SPCT and end of life care in general. Ward staff also received an induction in mortuary duties and responsibilities. This session left ward staff aware of the basics of last offices, the mortuary infection control practices and information around mortuary ethics and patient dignity. This training was also provided to both emergency department and theatre staff. An audit of last offices from August 2017 showed that of 58 patients, 23 last offices were not done well (40%). 12 were done well, 22 were adequate and one was not seen by mortuary staff. When asked why 40% were not done well, mortuary staff informed us that this was due to tape being used on sheets that covered the patients face. The staff endeavoured to learn from the audits and the audit results improved each month.

Porters received their own training regarding infection control, practices for moving and transfer of the deceased and practical guidance on using the hoist, identifying the correct tray size for the deceased and how to fill in the mortuary register.

The medical devices coordinator ensured that all staff were trained in the use and safe practices of syringe pumps.

Staff we spoke with on the wards informed us that having the SPCT available to provide support regarding palliative care was invaluable. Staff explained that the focus on end of life care enabled them to better care for end of life patients.

Nursing revalidation is the new process by which registered nurses are required to demonstrate on a regular basis that they are up to date and fit to practice. The trust was actively supporting the nursing staff throughout the Nursing and Midwifery Council (NMC) revalidation process by providing learning sessions.

All SPCT staff had received an appraisal in the 12 months prior to our inspection.

A split by staff group can be seen in the graph below:

<table>
<thead>
<tr>
<th>AC - End of life care</th>
<th>No. staff required (YTD)</th>
<th>No. staff who have received an appraisal (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>7</td>
<td>7</td>
<td>100%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>4</td>
<td>3</td>
<td>75%</td>
</tr>
</tbody>
</table>

During the reporting period, this core service reported no cases where staff were either suspended or placed under supervision.

11 (Source: Routine Provider Information Request (RPIR) P43 Appraisals)
Multidisciplinary working
Staff, teams and services within and across the service worked well together to deliver effective care and treatment. The care records that we examined confirmed involvement from health professionals such as occupational therapists, physiotherapists and dietitians, where necessary.

Relevant professionals were involved in the assessment, planning and delivery of patient care. We observed good working relationships between a range of health professionals both within the trust, and from external agencies. At the multidisciplinary team (MDT) meeting we attended, we saw all clinical nurse specialists (CNSs) and consultants from the SPCT were in attendance, along with the chaplain, an occupational therapist, a lead nurse, a clinical psychologist and the MDT coordinator. The meeting addressed patients’ needs and risk assessments.

The SPCT liaised with local hospices, community services and carers to provide continuity of care for palliative patients upon discharge from the trust.

Seven-day services
The SPCT operated from Monday to Friday, 9am to 5pm. Out of hours, advice was sought from a local hospice where a specialist nurse would offer assistance. If the nurse could not help, she could escalate the concern to an on-call palliative consultant.

The bereavement office was open from 8.30am to 1pm, Monday to Friday.

Health promotion
All staff across the trust that we spoke to told us that patients at the end of life were prioritised. We saw that community teams worked hard to help patients maintain their independence, manage their own health and prevent unnecessary hospitalisation. There was a clear focus on enabling patients to make choices about their care and decide for themselves (wherever possible) the direction of their treatment. This included where active treatment was to be withdrawn, as well as where limits to treatment were agreed.

We saw that the wards had posters on flu, wellbeing, stroke, smoking cessation and healthy eating.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
In all ten records we reviewed we found legible consent forms for various procedures. We also observed staff gaining consent before giving care and treatment.

During our last inspection, we found that in Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) documentation, where a patient was noted as lacking capacity, there was no accompanying mental capacity form. Whilst the service had taken strides to ensure staff awareness of their roles and responsibilities under the Mental Capacity Act (2005), there still concerns that this was not fully embedded. Of the 15 DNACPR records we checked, we found that two patients were found not to have capacity to make decisions relating to resuscitation. However, on looking through the notes we did not find the accompanying mental capacity documentation.
On both occasions, we highlighted this issue with a member of the SPCT, who immediately escalated the concern to ward staff.

Staff were aware of the processes in place to apply for Deprivation of Liberty Safeguards (DoLS) where this was identified as an issue. This is to ensure that patients in hospitals, care homes or assisted living are looked after in a way that does not inappropriately restrict their freedom. At the time of our inspection, no SPCT patients were subject to a DoLS application.

**Is the service caring?**

**Compassionate care**

Staff treated patients compassionately and adapted care to meet the needs of each patient. The four patients and three relatives we spoke with all provided positive feedback about the treatment and care they received. Relatives described staff as “very kind” and “supportive” and patients informed us that they felt “very cared for”. We reviewed cards that patients and relatives had sent to SPCT members. Comments included: ‘Thank you so much for the care and support’ and, ‘We couldn’t have done it without you’.

Through multidisciplinary meetings, we observed staff taking measures to ensure that patients were cared for in a holistic manner. When discussing a patient, the team would ensure that a patient’s private life was taken into consideration as well as the effect treatment was having on a patient’s relatives. A consultant informed us that, “Patient care is at the heart of what we do, it’s the most important thing”. A clinical nurse specialist described how “difficult end of life care is on the families.” She added, “We try to do our best for the patient and the families”.

The mortuary staff were passionate and committed to ensuring that the deceased were cared for with compassion and respect, both before and after death. Although no body viewings were taking place during our inspection due to capacity issues, the mortuary staff explained to us how they would usually try to make the process of viewing the deceased loved one as seamless as possible for the relatives. The staff understood that certain religions required burial as soon as possible after death and worked hard with the bereavement team to ensure all paperwork was completed.

The porters transported the deceased from the wards to the mortuary. The porters informed us that they would treat the deceased “as if they’re our own family”. The porters would aim to retrieve the deceased body within 20 minutes, aiming to take no longer than one hour.

On the wards, the SPCT were instrumental in making them more family-friendly. On the two end of life care showcase wards (Hayes and Grange), the SPCT had received a grant and refurbished the family rooms on both wards. These rooms were now places where family members could go to have difficult conversations and for some general quiet time.

Both porters and mortuary staff stated that ward staff handled deceased bodies with due care and consideration.

**Emotional support**

The clinical psychologist team who worked with the SPCT and the bereavement office provided formal emotional support. The clinical psychologist team saw patients, family members and carers
and offered counselling and bereavement support. There was no waiting list for palliative patients requiring clinical psychology input and patients had on average three to four sessions where required. The bereavement team conducted interviews with families, provided death certificates and could signpost patients and relatives to counselling within other services. The bereavement service sent out a survey to relatives after a death, detailing how to get additional support if necessary.

The head of spiritual care was a Christian chaplain. This was a full-time role supported by volunteers. On site, there was a multi-faith chapel which was open every day, an Islamic prayer room with prayer mats available and the chaplain’s office. The chaplain was alerted to patient needs by the ward staff, who would call or email to ask for assistance. The chaplain informed us that he could contact local spiritual leaders from a range of faith groups to support patients who were not Christians. The chaplain also offered support to patients and those close to them, no matter what the patient faith, or indeed if the patient had no faith at all. This was especially the case for patients with no family.

We looked at a comment card from a family member dated November 2017. The family member stated that in the last 12 hours of the patient’s life they were moved to a side room. The family member went on to say that the SPCT provided “amazing care and the compassion showed to us was inspirational”.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. Patients and relatives told us that they felt involved in care planning and in making decisions based on their informed consent. Staff highlighted the importance of working collaboratively with patients’ family members and would always try to include family members in care planning. We observed a member of the SPCT speaking with the son of a patient who was in the last few weeks of life. The son of the patient was involved in decisions about treatment and care and was very grateful to the team for their explanations.

Of the ten records we looked at, all had evidence of family involvement where applicable. Relatives informed us that they “felt very involved by the SPCT”. We also observed interactions between the SPCT and patients’ relatives. These conversations were very clear and compassionate. Relatives were always able to ask questions and the team responded with accurate and clear information.

Since our last inspection, the service had created a ‘Caring for your loved one’ leaflet. This successfully outlined the expectations for a relative whose loved one was being treated under the palliative care pathway. The leaflet came with advice about caring for a loved one, the death of a loved one and contact details for different services where appropriate. This leaflet was available in seven different languages which adequately represented the patient based that the Hillingdon served.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people.
There were no designated palliative care beds, but staff made every effort to treat palliative patients in single rooms. This meant that patients at the end of their lives and those close to them could be cared for in privacy and with dignity. Where patients preferred to be cared for in a nightingale ward, staff made every effort to accommodate this. A nightingale ward is a type of ward that contains one large room with curtains to divide between patient bays. Staff informed us that some palliative patients preferred this style of ward as it meant they were not isolated.

To accommodate patient relatives, the SPCT had access to Z beds. These beds could be brought into the patient room by the estates team and patient relatives could stay the night if necessary. The SPCT also had access to comfort packs. These packs could be provided to patients’ relatives and contained an eye-mask, toothbrush, toothpaste and other essentials so that relatives could stay the night.

At the time of our last inspection, we noted that the service had limited access to private rooms in which to have sensitive conversations with patients and their family members. The service had worked towards correcting this since our last inspection, particularly on their two end of life showcase wards. These two wards had each undergone significant changes since our last inspection. Both wards were now equipped with private family rooms and the doctors room on each ward had been refurbished, with new reference materials added that were dedicated to the care of palliative patients. The service had plans to roll out similar changes across all wards on in the trust that accepted palliative patients.

The team made significant effort to deliver services suitable for the patient base they served. The team identified that the geography of the borough meant that half of their patients may find it difficult to travel to attend clinics in the hospital. To meet the needs of these patients, the staff split their clinics between the north and the south of the borough. This ensured that the patients and those caring for them never had to travel too far for clinics. The service also had ten ring-fenced beds in a nearby hospice that they could utilise. SPCT staff informed us that this agreement worked well with patients who were not quite ready to go home.

The SPCT was available five days a week, from 9am to 5pm, Monday to Friday. The team provided advice and face-to-face contact for patients with complex palliative care needs. Outside of these hours, advice was provided by the local hospice via telephone. All staff on the wards that we spoke with were aware of the number to call and the escalation process out of hours.

The largest ethnic group within the trust catchment area was white British, with 43% of the population coming from this background.

**Meeting people’s individual needs**

Patients’ spiritual, religious, psychological and social needs were taken into account when care was provided. The SPCT team was varied and contained the specialities necessary to take account of patients’ individual needs. We observed discussions between the staff about the holistic needs of the patient and the patient’s family. The team coordinated care in order to ensure that family members received the necessary support. This was confirmed by the medical records we looked at, which discussed patients’ needs as well as their families.
The religious and spiritual needs of the patients was taken into consideration by the service. The chaplain sat in on all MDT meetings. The chaplain was supported by a team of volunteers. The SPCT liaised directly with the chaplain who offered advice and support. On site there was a multi-faith chapel that could be used by all faiths and also an Islamic prayer room, with prayer mats available. Patients also had access to other faith ministers, chaplains and imams. The chaplaincy service could arrange this.

The trust’s comfort care plan was based on the individualised end of life care plan. This utilised the five key priorities for care, drawn from the national “One chance to get it right” report, written by the Leadership Alliance for the Care of Dying People (2014). The individual needs and personal choices of patients were recorded in these plans.

The service put in provisions for end of life care patients from disadvantaged groups. For example, we observed the SPCT MDT conversation for a patient from a traveller background. The team worked together to ensure that the patient was cared for as an individual. We also observed the same level of consideration for a patient who did not speak English. There was no learning disability lead for the trust but service had leaflets for patients with learning disabilities and dementia. These leaflets were all available in other languages upon request.

The trust had processes in place to support the relatives and carers of patients who were identified as being at the end of their life. For example, they provided vouchers for reduced rates of car parking. Relatives and carers of patients at the end of their lives were allowed to visit the wards at any time of day.

Translation services were available and staff were familiar with the process for booking an interpreter. Translation services were provided via a telephone interpreter and also by face-to-face interpreters.

**Access and flow**

In the year prior to our inspection there were 827 deaths reported in the service. In the year prior to PCT had input in 44% of cases as these cases were complex enough to warrant specialist input. Of these referred patients, 91% of patients were seen within one day of referral. Staff spoke to were aware of processes relating to rapid discharge to enable patients to die in their preferred place of death (PPD). The majority of patients (85%) died in their preferred place of death.

The average caseload of each clinical nurse specialist (CNS) was 192 patients throughout the year. This was shared throughout the team daily. CNS’ informed us that they were able to manage their caseload effectively and whilst they were busy, they did not feel inundated. We observed CNS’ increasing their caseload to take on patients or patients family members whom they had previously treated.

In the year prior to our inspection, 46% of the patient base were non-malignant patients and 54% were patients with malignancies. This shows that the trust has effective specialities that can deal with palliative patients with or without cancer.

Data on bed moves was not readily available as the trust did not collate this data. We were informed by the trust that ward moves for non-clinical reasons were generally avoided if a patient
had already been moved once. We saw no evidence of palliative patients being moved once they had been admitted.

Staff had access to an up-to-date advanced care planning web-based register and to patients’ paper medical records. This ensured continuity of care for the patients.

**Learning from complaints and concerns**

The service informed us that they received very few complaints throughout the year. Any complaints would first be managed on an informal basis initially. The complaints process was clear and easy to understand and patients received leaflets on how to complain formally.

From November 2016 to November 2017 there were two complaints relating to end of life care within the trust. These two complaints related to general care and treatment. The trust took an average of 56 days to investigate and close the complaints; this is not in line with their complaints policy, which states complaints should be closed within 30 days. The service provided no reasons as to why it took so long to respond to formal complaints.

**Is the service well-led?**

**Leadership**

There was clear local leadership that encouraged and supported the delivery of person centred care. This was evident in all of the services we visited, including the specialist palliative care team, the mortuary service, the bereavement service and the chaplaincy service.

At the time of our last inspection, it was not clear who held the operational oversight for end of life care services. Since then, the service had developed a clear senior management structure and had made significant changes in this regard. A triumvirate leadership team was formed in December 2017, comprising one of the palliative care consultants, the lead nurse for end of life care and the overall lead for the SPCT. The End of Life Care (EOLC) board had a Non-Executive Director (NED). The board met every quarter and information from those meetings was fed to the trust board.

At the time of our inspection, the bereavement service and mortuary were managed by the chief pharmacist. The team stated that they felt supported in their role and had no issues with this arrangement. The chaplain fed into the patient experience team and sat on MDTs, quarterly board meetings and bereavement committees.

**Vision and strategy**

At the time of our last inspection, the service did not have an end of life strategy. Since our last inspection, the service had developed a strategy. The strategy was dated from 2016 to 2020. The vision for end of life care was for ‘Patients at the end of their lives receive the best quality, patient centred, individualised care, with their loved ones involved and supported, all provided by staff who are prepared, able and confident to care.’ This vision was distinct from the trust vision which was to be an ‘outstanding provider of healthcare’. All staff had access to the strategy either in paper form or on the hospital intranet and knew about the CARES values.
Culture
Members of the executive team and managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff were proud of their work and the quality of service that was delivered to patients and relatives.

The SPCT were proud to present an evidence folder of all the changes they had made since the last inspection. We found that the team were passionate about the work that they did and were eager to showcase the work of their colleagues within the team. The SPCT were a small team who worked well together. They shared a single vision of promoting the awareness of the team and doing their best for their patients.

Throughout our inspection, we found staff of all levels with an embedded awareness of the role of the SPCT. Senior nursing staff on the wards felt more confident with caring for patients at the end of life, but also felt supported by the SPCT if they had any queries or concerns. Junior nursing staff on the wards knew who the SPCT were and who to contact for advice, both within and out of hours. Overall, nurses told us that the SPCT were very supportive and encouraging.

Governance
The trust used a systematic approach to continually improving the quality of its service. There were systems in place to report information gained from auditing and improvement action plans.

The End of Life Care (EOLC) board had a head and a Non-Executive Director (NED). The board met every quarter and information from those meetings was fed to the trust board. The committees that fed into the board were: the patient safety committee, the regulation and compliance committee, the external services scrutiny committee and reports from the experience and engagement groups. We reviewed minutes from the EOLC board meeting that took place shortly before our inspection and found them to be thorough. Issues from the end of life service were discussed at the bi-monthly quality and safety committee and this fed into the board meetings. The mortuary manager also sat in on these meetings.

The daily input that the SPCT had into the wards ensured that they were continuously aware of ward staff EOLC treatment. Staff could ask questions and the SPCT worked with staff to ensure that the patient was receiving good end of life care.

Management of risk, issues and performance
At our last inspection, we found no evidence of end of life care risks on the local or overall trust risk register. Since then, the service had adopted a risk register which contained one active risk at the time of our inspection. This tallied with our assessment of risks. This was related to the risk that “patients may receive suboptimal, uncoordinated care in the last year of life resulting in unnecessary hospital admissions and reduced quality of life”. This risk was rated as ‘moderate’ and identified that various gaps in end of life care planning that could result in the risk. Whilst on inspection, we found that this risk was mitigated by the SPCT way of working. This risk and any others that could arise were discussed at the quarterly audit and risk committee. The minutes from
this committee fed into the quarterly board meeting. Whilst on inspection we did not identify any further risks.

Informally, the SPCT would usually meet once a day to discuss any operational issues.

In the event of an emergency, the mortuary could rely on local undertakers with whom they had a service level agreement. The local undertaker could provide more body store space if required.

**Information management**

There were arrangements and processes to ensure all relevant staff had access to information required to deliver safe care and treatment. Staff had access to up-to-date, accurate and comprehensive information.

Staff had access to an up-to-date advanced care planning web-based register and to patients’ paper medical records.

**Engagement**

Since our last inspection, the service had created bespoke discharge summaries that communicated the patient’s plans and wishes regarding their future care. The staff on the wards found this useful and told us that it was comforting to know that this information was recorded accurately.

In 2017, the service took part in ‘Dying Matters’ week for the first time. ‘Dying Matters’ was set up in 2009 by the National Council for Palliative Care (NCPC) and aimed to promote public awareness of dying, death and bereavement. The aim of the week is to help people talk more openly about dying, death and bereavement, and to make plans for the end of life. Through ‘Dying Matters’ week, the service was able to engage with over 400 hospital users and over 50 staff members.

After our last inspection, the service aimed to engage the wider hospital with the end of life service and this was named as a priority on the trust’s quality schedule. Since then the service has given EOLC presentations to the critical care team, the deteriorating patient group, the resuscitation group and various other staff members across the trust.

The service were regular contributors to the trust intranet. Across the wards, the staff reported they were well aware of the work the service did.

**Learning, continuous improvement and innovation**

Various improvements had taken place across the service since we last inspected. This included the development of an end of life strategy, various ward based improvement initiatives such as the introduction of resource folders, and the overall increase in hospital-wide awareness of end of life care. The trust was committed to improving end of life care services via training, learning from subgroups and improving access to the end of life care team.
The service was looking forward to the hiring of a new full-time end of life care facilitator. The trust had approved the funding for this post and at the time of our inspection this joint venture with Macmillan was underway. The successful candidate in this role was due to be fully instated by July 2018.

The service was also working with the wider trust, the clinical commissioning group (CCG) and another local trust to develop the end of life care single point of access (SPA). The team were successful in a bid process securing £1.4 million from a not-for-profit organisation and were using the funds to resource the SPA. This tool would fully integrate services for adult patients on a palliative pathway within the borough. The SPA would mean that patients and their carers could call up a support line staffed by a palliative care nurse, who would be available 24 hours a day, seven days a week. This nurse would be able to provide advice over the phone and could coordinate care, ensuring that patients and their carers had a single point of contact for accessing a range of professional help. The service was due to go live in Spring 2018.

The service had developed a sound rapport with NHS Improvement (NHSI). The service received an NHSI award for innovation implemented at a pace, and the trust scored 55.7 on the NHSI sustainability model exercise. Any score of 55 or higher indicted the likelihood of sustainability as ‘good’.
Outpatients

Facts and data about this service

Outpatient services at the trust are spread over two main sites at Hillingdon Hospital and Mount Vernon Hospital as well as some community locations which including GP Practices, Health Centres and Schools.

The trust hosts different speciality/sub specialities clinics including “one stop clinics” in Breast Care, Cardiology, Transient Ischaemia Attack (TIA) clinic and Care of the Elderly clinics.

Source: Routine Provider Information Request (RPIR) – Context acute

Total number of appointments compared to England

The trust had 381,756 first and follow up outpatient appointments from October 2016 to September 2017. The graph below represents how this compares to other trusts.

(Source: HES - Outpatient)

Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from October 2016 to September 2017.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
</table>

20171116 900885 Post-inspection Evidence appendix template v3 Page 260
<table>
<thead>
<tr>
<th>Hospital</th>
<th>Appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hillingdon Hospital</td>
<td>344,224</td>
</tr>
<tr>
<td>Mount Vernon Hospital Site</td>
<td>61,157</td>
</tr>
<tr>
<td>Oakland Medical Centre</td>
<td>3,597</td>
</tr>
<tr>
<td>Eastbury Surgery</td>
<td>2,971</td>
</tr>
<tr>
<td>Uxbridge Children's Centre</td>
<td>1,886</td>
</tr>
<tr>
<td>This Trust</td>
<td>422,191</td>
</tr>
<tr>
<td>England Total</td>
<td>103,794,079</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

**Type of appointments**

The chart below shows the percentage breakdown of the type of outpatient appointments from October 2016 to September 2017. The percentage of these appointments by type can be found in the chart below:

**Number of appointments at The Hillingdon Hospitals NHS Foundation Trust from October 2016 to September 2017 by site and type of appointment**

(Source: Hospital Episode Statistics)
**Mandatory Training**

The trust set targets between 80-95% for completion of mandatory training.

Outpatient and directorate managers told us that the mandatory training rates had improved since our data original data request. The trust provided data for mandatory training rates as of March 2018, shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Completion (%)</th>
<th>Target Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Basic Life Support Level 1 [Once Only]</td>
<td>80%</td>
<td>93%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support Level 2 [1 Year]</td>
<td>80%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood &amp; Blood [2 Years]</td>
<td>80%</td>
<td>87%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution [3 Years]</td>
<td>80%</td>
<td>91%</td>
<td>Yes</td>
</tr>
<tr>
<td>Corporate Induction [Once]</td>
<td>80%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity [3 Years]</td>
<td>80%</td>
<td>93%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, Safety &amp; Welfare [3 Years]</td>
<td>80%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control Level 1 [3 Years]</td>
<td>90%</td>
<td>89%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control Level 2 [1 Year]</td>
<td>90%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance [1 Year]</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; Handling Level 1 [3 Years]</td>
<td>80%</td>
<td>71%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; Handling Level 2 [2 Years]</td>
<td>80%</td>
<td>91%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Mandatory training was delivered as mix of both electronic learning and classroom sessions. The trust recently implemented the “I develop” training app which was accessible via the trust intranet. The app was designed so that individual staff could self-manage their training needs; mandatory training that was due was flagged to individual staff members alongside their lead nurses and line managers. Staff were also able to book other non-mandatory training through this app.

Staff mandatory training was managed by linking it with staff appraisals. Staff that had not completed all their training could not move on to the next salary increment in their respective pay band. Staff training was also discussed during divisional meetings. Managers told us that the new training app has helped improve compliance as it allowed for a clearer data monitoring.

**Safeguarding**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information on staffing groups. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

The trust set targets between 80-90% for completion of safeguarding training.
Due to the RPIR data being below trust target, we requested data as of March 2018 shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Completion (%) YTD</th>
<th>Target Met Yes /No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults [3 Years]</td>
<td>80</td>
<td>91%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 [3 Years]</td>
<td>90</td>
<td>91%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 [3 Years]</td>
<td>90</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3 [3 Years]</td>
<td>90</td>
<td>100%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

We were told that all staff received Adult and children safeguarding training level 1 and 2. Matrons would receive level 3 training, however due to a recent safeguarding referral in relation to a child all band five and six nurses are also being provided with children’s safeguarding training level 3.

The trust had clear and comprehensive policies, processes and training related to safeguarding for adults and children. The safeguarding team and the trust board regularly reviewed policies ensuring they were up to date. Staff told us they could find policies easily from the trust intranet and understood their responsibilities and said the safeguarding team were supportive and accessible.

The outpatient staff showed good understanding the trust safeguarding polices and nursing staff we spoke with could describe in detail how they would process a possible safeguarding incident. We were told by managers that staff would complete a DATIX form and refer the incident to their lead nurse who would if required refer it to the matron, the appropriate safeguarding team would be contacted for support. The trust safeguarding lead would be notified by the matron.

Managers told us that there had been two safeguarding referrals made within the last 12 months, one being for adults and the other for children. We were provided evidence to show detail on the incidents and highlight that the correct process had been followed. Feedback to the referring staff member was provided at the end of each investigation.

**Cleanliness, infection control and hygiene**

All outpatient areas we observed and facilities we inspected were visibly clean and tidy. There were regular cleaning schedules in place. Staff had sufficient access to hand washing facilities and hand sanitisers. We observed staff following hand hygiene guidelines. We observed that all nursing staff and allied health staff followed the bare below the elbow guidelines however, some medical staff did not. Staff demonstrated good understanding of infection prevention and control. Personal protective equipment was available for staff.

Cleaners we spoke with were aware of appropriate infection control measures to take in relation to clinical and non-clinical waste. All cleaning staff we observed wore adequate personal protective equipment and adhered to the trust infection control policy. We saw completed cleaning schedules and toy cleaning schedules.

We observed that staff were aware of the trust sharps policy and sharps bins were managed appropriately. The bins were labelled and stored correctly in compliance with the Health Technical Memorandum and the safe management and disposal of health care waste guidelines from the Department of Health.
The trust utilised a colour coded system for the separation of offensive, hazardous and non-clinical waste. The waste was managed, stored and disposed of in compliance to the EU waste regulations (The waste framework directive 2008/98/EU).

The trust had an infection prevention and control policy and infection prevention strategy in place, which was monitored by the infection prevention and control team. The Infection prevention and control team provided clinical support for staff. Nursing staff we spoke with told us that outpatient services had a good working relationship with the infection prevention and control team.

We observed the use of green “I am clean” stickers on equipment and there was a cleaning schedule for all equipment. We observed staff clean reusable medical equipment and decontaminate flexible endoscopes available in some clinic rooms in compliance with the Health Technical Memorandum and the safe management and disposal of health care waste guidelines from the Department of Health.

The clinical support services directorate provided the following data for hand hygiene, bare below the elbow and quick question compliance for the period of April 2017 to February 2018:

<table>
<thead>
<tr>
<th>Hand Hygiene Percentage</th>
<th>Bare Below the Elbows</th>
<th>Quick Question Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr  May  Jun</td>
<td>Apr  May  Jun</td>
<td>Apr  May  Jun</td>
</tr>
<tr>
<td>Cumberledge</td>
<td>93% 90% 92%</td>
<td>86% 90% 100%</td>
</tr>
<tr>
<td>Diabeticare</td>
<td>100% 92% 100%</td>
<td>100% 100% 100%</td>
</tr>
<tr>
<td>Elderly Day Care</td>
<td>100% 90% 100%</td>
<td>100% 100% 100%</td>
</tr>
<tr>
<td>Eye/ENT Clinic</td>
<td>100% 100% 100%</td>
<td>100% 100% 100%</td>
</tr>
<tr>
<td>Outpatient Department THH</td>
<td>100% 100% 95%</td>
<td>95% 95% 100%</td>
</tr>
<tr>
<td>Oral and Maxillofacial Clinic</td>
<td>100% 100% 100%</td>
<td>87% 100% 93%</td>
</tr>
<tr>
<td>X Ray THH</td>
<td>90% 90% 95%</td>
<td>95% 95% 100%</td>
</tr>
<tr>
<td>OPD MVH</td>
<td>100% 100% 100%</td>
<td>94% 80% 100%</td>
</tr>
<tr>
<td>Direcorate Compliance</td>
<td>98% 95% 98%</td>
<td>94% 95% 99%</td>
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### Hand Hygiene Percentage

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<th>Aug</th>
<th>Sep</th>
<th>Jul</th>
<th>Aug</th>
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<th>Jul</th>
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<tr>
<td>Diabeticare</td>
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<tr>
<td>Elderly Day Care</td>
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<td>67%</td>
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### Hand Hygiene Percentage

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<th>Oct</th>
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### Hand Hygiene Percentage

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</tbody>
</table>
Environment and equipment
Most clinics were held in the main outpatient department; however, some speciality clinics and one stop shop services were held in other areas of the hospital. The hospital had a large estates maintenance backlog and this was observed to have some impact on the service. We observed in one case a broken window in one of the outpatient consulting rooms, the senior nursing staff told us that this issue was reported to the estates team in July 2017 and was still yet to be resolved.

Due to the age of the building the department design and layout was not ideal, however the department had appropriately configured services to the best of what was available. In some areas we observed the department was not large enough to suitably accommodate patients and those who may accompany them, one example being the ophthalmology clinic area which became quite cramped during busier periods and additional seating had to be put in adjoining corridors.

The ambient room temperature of the storage room in the main outpatient department was 37 degrees at the time of the inspection. When we alerted staff to this they told us that this was normal and that it was named the ‘hot room’. This was a small storage room overfilled with stationery and documents; we found this to be concerning due to a potential fire risk.

All resuscitation trollies that were checked were found to be sealed and in date. All outpatient services had access to defibrillator units. We observed that other equipment was maintained appropriately and cleaned regularly.

Safety testing for portable appliances was done by the trust on an annual basis. All devices we checked during inspection were valid with the previous inspection date recorded on a sticker, except two laser treatment machines which did not have any indication of previous testing and one laser cooling machine which was last tested in 2012.

Assessing and responding to patient risk
We were told by managers that all outpatient staff prioritised transport patients so they are seen as early and as promptly as possible. Stretcher patients were reviewed at the start of each clinic and were allocated a room which could accommodate a stretcher and hoist should this be needed. We were told by nursing staff that patients living with learning difficulties, dementia or other mental health conditions were prioritised and reviewed as soon as possible, nurse leaders ensured that clinics held extended appointments slots if required.

We observed that patients that had infections or possible contagious illnesses were reviewed as the last patient of any clinic. Nursing staff told us that access was only granted for relevant team members and that a deep clean was organised with the rapid response cleaning team post review. Dermatology and dental specialties completed pre-assessment questionnaires to determine patient’s individual care needs and to check if any adjustments to the appointment were required. Similar practices were adopted by clinical nurse specialists (CNS) of specialty pathways such as breast and gynaecology.

We were told by nursing staff that if a deteriorating patient was identified a risk assessment would be completed as quickly as possible by the lead nurse in the area. The nurses would screen the area for patient privacy and dignity and then call the local outpatient medical staff to provide an
initial assessment. The patient would then either be transferred to the emergency department or the crash team would be called.

Staff had access to a mental health liaison team and who were on site 24 hours a day and staff could make referrals through a computer system. If the case was urgent or further discussion was needed, staff could contact the team by telephone.

We observed that the dermatology service utilised laser machines for the treatment of patients. We were not assured that the trust followed the Medicines and Healthcare Products Regulatory Agency (MHRA) laser safety requirements. We observed that there were four lasers within the dermatology service; however, this was not the same number of devices recorded in the trust medical devices inventory log. The service was performing laser treatments since 2012 and was operating without a laser protection advisor, when the assistant director of health and safety and the medical devices compliance advisor were notified of this finding they explained that the trust had just appointed a laser protection advisor as of February 2018, we were provided email and invoice evidence of this. The local rules were not compiled as per the MHRA requirements and there also was no evidence of laser safety audits and a laser policy, however the nursing staff assured us the relevant safety checks were conducted prior to every use. We were not assured that staff utilising the laser machines had adequate updated training as the trust showed us training certificates from the year 2000 and 1998 and told us that staff had not received any further training since then.

Nurse staffing
The Hillingdon Hospital have reported their staffing numbers below for the period April 2017 to November 2017. Nursing staff reached 100% of planned capacity as at November 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Planned Staff</th>
<th>Number in post as at November 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Hillingdon Hospital</td>
<td>64.8</td>
<td>64.7</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From December 2016 to November 2017, Hillingdon Hospital reported a vacancy rate of 12% in outpatients for qualified nursing staff, compared to the trust’s overall vacancy target rate of 8%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Data provided showed that as of January 2018 the vacancy rate had improved to 5% which was within the trust target.

From December 2016 to November 2017, Hillingdon Hospital reported a turnover rate of 28% in outpatients, compared to the trust target of 13%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Data provided showed that as of January 2018 the turnover rate had improved to 1.5% which was within the trust target.
From December 2016 to November 2017, Hillingdon Hospital reported a sickness rate of 3% in outpatients for qualified nursing staff, which was the same as the trust target.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. This will need to be requested during the inspection as part of standardised requests. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

Outpatients had 3,552 shifts filled by bank staff which was the fourth highest within the trust.

The trust did not provide accurate data for the total number of shifts overall and therefore we are unable to calculate the total number of shifts covered by bank and agency and the number of shifts left unfilled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Managerial staff explained to us that the outpatient services did not use agency staff and only used regular bank staff. All bank staff were provided with local departmental inductions and training was monitored the same way as for permanent staff.

Managerial staff told us that department only had one band six, band seven and assistant staff vacancy each for those roles. They also told us that turnover for qualified staff was not high and most staff in the department had been employed for long periods of time. Turnover for assistant staff was higher and that this was due to staff usually leaving for career advancement. Divisional leads told us about recent trust initiatives to recruit from overseas to fill nursing vacancies across the hospital.

Nursing staff we spoke with told us they felt that the department could still use more staff. Senior nurses told us that they struggled to complete their managerial duties when staff were absent due to sickness. Managerial staff told us that although bank staff were requested whenever they were needed, at times bank staff would not accept the shift and the shift would go unfilled. Senior nurses were expected to prioritise their clinical duties and fill the shifts; they could call matrons for support. Divisional leads expressed the trust priority to not use agency staff if possible; however, when asked regarding unfilled shifts they told us they monitor the situation daily and would not allow dangerous practice.

Medical staffing

The Hillingdon Hospital have reported their staffing numbers below for the period April 2017 to November 2017. Medical staff reached 99% of planned capacity as at November 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Planned Staff</th>
<th>Number in post as at November 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Hillingdon Hospital</td>
<td>49.7</td>
<td>49.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)
From December 2016 to November 2017, Hillingdon Hospital reported a vacancy rate of 7% in outpatients for medical staff, compared to the trust’s overall vacancy target rate of 8%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From December 2016 to November 2017, Hillingdon Hospital reported a turnover rate of 32% in outpatients, compared to the trust target of 13%. Managerial staff told us that this was due to some consultant staff retiring and that the trust was actively recruiting new staff.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From December 2016 to November 2017, Hillingdon Hospital reported a sickness rate of 1% in outpatients for medical staff, compared to the trust target of 3%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. This will need to be requested during the inspection as part of standardised requests. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

The trust did not provide accurate data for the total number of shifts overall and therefore we are unable to calculate the total number of shifts covered by bank and locum and the number of shifts left unfilled.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Records
The trust used mainly paper records, with some electronic access to documents, we were told by managerial staff the trust was working towards moving to a paper light system. Paper records were stored in a storage room in the department. Records of clinic patients were requested two days prior to appointment to ensure all reports and tests were completed, records were sent to consultant secretary offices located on the hospital campus for dictation after appointments. Records were sent back to medical records after dictation.

Staff had electronic access to diagnostic results; however, staff told us imaging results were not always available in a timely manner due to delays in reporting of scans.

Managerial staff we spoke with told us that the department did not audit the availability of clinical records. Nursing staff we spoke with told us that clinical records not arriving when requested or being misplaced did cause occasional problems, but staff felt that generally there were not any significant issues.

We checked a total of 10 notes across different specialities in the outpatient department and we found a variation in the quality and completeness of those records. Out of the 10 records we reviewed for patients seen that day, five had written doctor entries that were not signed and dated and four did not contain an entry at all even though the patient was seen. Nursing staff we spoke with told us that some consultants did not create a written entry in the notes and instead dictated their notes to be later typed up by the secretaries as a letter. Some doctors we spoke with told us that they never created hand written entries and only dictated letters as patients were discussed and recorded in the multidisciplinary team (MDT) meeting notes, however in records with no
doctor entries we were unable to locate any recent MDT notes in two records we found MDT notes for 2016 and 2017.

From the notes we reviewed most of them contained loose letters, prescriptions, record pages that were not securely fastened to the folder. We also observed a variation in legibility of the written entries. All notes we reviewed had fully completed consent forms, documentation from previous inpatient stays, completed observations for patients, diagnostic test results and previous clinic, discharge and referral letters.

We requested to see documentation audits; however, we did not receive this data. We were told by managerial and nursing staff that the department did not conduct regular documentation audits or any other audits to check the quality of the notes and that this was done by a central trust team. Outpatient staff told us that the main errors in relation to clinical records were staff misfiling notes in the incorrect record. Some specialties have adopted a tracking system so that errors become accountable.

**Medicines**

We saw that medicines were stored appropriately. Controlled drugs (CDs) are medications requiring additional security. Staff we spoke with were aware of the appropriate safety measures required and knew how to access medication policies on the trust intranet. There were lockable cupboards in each area for keeping controlled drugs and keys were held by the nurse in charge.

Medications were recorded on patient records; however, we saw that these were not always clear and legible on the records we viewed.

Medicines were stored in dedicated medication fridges which had daily temperature checks. Temperature logs we looked at showed that the fridges had not exceeded the acceptable temperature limits; however, we noticed that there were periods where the fridges had not been checked. Ambient room temperatures were also checked and logged and we saw that they did not exceed recommended levels.

Prescription sheets were stored securely in the sister’s office in a locked drawer. Nursing staff told us that prescription sheets were only provided to doctors when requested and only one sheet at a time. Each prescription sheet was scanned and sent to pharmacy and this was stored for an audit trail.

**Incidents**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2016 to November 2017, the trust reported no incidents classified as never events for outpatients.

(Source: Strategic Executive Information System (STEIS))
In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from December 2016 to November 2017.

(Source: Strategic Executive Information System (STEIS))

Incidents were reported via an electronic system and the root cause analysis was undertaken by the lead area nurses or matrons. Nursing staff we spoke with had a good understanding of how to report an incident and we were also told that feedback was provided to the reporter. We saw evidence that showed incidents were discussed at departmental and divisional meetings and learnings from the incidents were disseminated via staff meetings.

Data provided to us showed that in the period of March 2017 to February 2018 there were a total of 214 incidents which related to outpatients out of which 152 were classified as no harm, 60 were low harm and two were moderate harm.

Nursing staff and medical staff we spoke with understood their responsibilities regarding duty of candour. Area leads explained that if any incident caused harm to a patient that a formal letter was issued by the trust and after the incident investigation was complete the patient was offered the incident report and conclusions at the end of the investigation.

We were told by managerial staff that the trust did not provide any formal training in relation to duty of candour, however this was discussed at team meetings where staff could ask questions and managers could raise awareness.

Safety Thermometer
Data for the trust from the safety thermometer website dashboard for December 2017 showed the following.

<table>
<thead>
<tr>
<th>Code</th>
<th>Organisation</th>
<th>Data point</th>
<th>Patients</th>
<th>Surveys</th>
<th>Harmfree#</th>
<th>Harmfree%</th>
<th>Ulcers#</th>
<th>Ulcers%</th>
<th>Falls#</th>
<th>Falls%</th>
<th>VTE#</th>
<th>VTE%</th>
<th>UTI#</th>
<th>UTI%</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAS</td>
<td>THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST</td>
<td>2017-12-01</td>
<td>410</td>
<td>23</td>
<td>392</td>
<td>95.61</td>
<td>10</td>
<td>2.44</td>
<td>0</td>
<td>0.00</td>
<td>2</td>
<td>0.49</td>
<td>7</td>
<td>1.71</td>
</tr>
</tbody>
</table>

Is the service effective?

Evidence-based care and treatment
NICE guidance was disseminated by the trust governance team to the divisional audit and guidelines lead who in turn disseminated it to matrons via the divisional governance meetings and the matrons informed the relevant area leads. NICE guidelines were discussed at staff meetings and implemented if relevant. We saw evidence of policies and work instruction incorporating NICE guidance.

We were told by consultants working in rheumatology that they were unable to follow NICE guidance regarding monthly monitoring for rheumatology patients that were recently diagnosed. Consultants told us that due to a lack of resources and an increasing capacity they were unable to
do this, however they were working with the nurses to develop a monthly nurse led clinic to meet this guideline.

All staff we spoke with told us that they could access trust policies and local work protocols via the intranet or shared drive.

Nursing staff we spoke with told us that the department did not regularly undertake any specific audits to check working practices against written guidelines. We requested a local audit programme specific to outpatients but we did not receive this from the trust.

We were provided evidence to show that the department regularly undertook a referral to treatment time audit to check if case information by doctors provided to the divisional leads was correct.

We were provided evidence to show that an audit was undertaken in October 2016 to determine if the process of stamping notes for children that had not attended was being followed, to check if there was a Child Protection Plan and that notes had been marked accordingly, to check if correspondence had been sent to the GP for all children that did not attend and that any necessary correspondence was sent to the social workers. Compliance was noted to be 87% out of the 100 clinical records checked.

Managerial staff told us about the department regularly auditing clinic delays and if extra clinics were required, they told us that this information was monitored and used to assess how improvements could be made to the service. We were given the example of the data showing that a speciality clinic being regularly delayed, the solution was to provide extend the time allowed for the clinic to run and spacing the appointments out more evenly, this allowed for the clinic to run to time and patients not having to wait unnecessarily. We were provided data showing the total delay in minutes per consultant clinic per specialities for a random week in January 2017 and March 2017.

Managerial staff also told us about a patient demographic audit to check if the correct information on the trust administration system was shared with the reception staff to ascertain if the correct information was available to them when the patient presented, however we were not provided data regarding this audit.

Clinical nurse specialists (CNS) ran telephone clinics for their specific areas, patients we spoke with told us they found these telephone calls to be reassuring. The CNS’s told us these clinics were designed to provide specialised advice to patients and to provide a quick route back to the clinic if they patient needed extra care.

**Nutrition and hydration**

The diabetic speciality ran special clinics for patients to receive specific tailored advice from a qualified dietitian. The majority of patients we spoke with told us they found this clinic useful and they were able to receive information which was specific to their needs and cultural background. Nursing staff told us this clinic was a regular occurrence to proactively manage the disease though a holistic approach.
Medical staff we spoke with told us they were able to make referrals to the trust dietitians if they felt it was needed for any patient they were seeing.

**Pain relief**
Nursing staff told us that any patients experiencing chronic pain would be referred to the pain management team. Doctors seeing patients would usually prescribe any pain relief they required. Patients with sudden pain that may be in a deteriorating state were assessed using the NEWS scoring system and asked to rate their pain on a scale from 0 to 10.

We observed nursing and medical staff enquire about pain and comfort to patients during clinics. We also saw evidence of pain relief prescriptions in clinic notes.

Some specialities such as rheumatology provided patients contact details that they could use when at home if they required further pain management or if they needed to discuss their current medication. These patients could be seen back in the clinic to adjust their medication.

**Patient outcomes**
From October 2016 to September 2017:
- The follow-up to new rate for Hillingdon Hospital was lower than the England average

**Follow-up to new rate, The Hillingdon Hospitals NHS Foundation Trust**

![Graph showing follow-up to new rate](image)

(Source: Hospital Episode Statistics)

Staff told us that the department did not hold any external accreditations and we requested this information from the trust to which we did not receive any information.

The divisional leads explained that the department as part of the trust participated in the national cancer audits commissioned by the Quality Surveillance Team from NHS England. The trusts cancer MDT teams and oncology services have submitted their self-declaration forms and once this has been reviewed by NHS England then they will be allocated further assessment. The services participating in this national audit from the clinical support services division will be acute oncology services, dermatology and HIV services.
The trust did participate in the national NHS benchmarking network outpatient project. We were provided data from their participation in 2016/17-year, divisional leads told us that the trust did participate in the 2017/18 year and will continue to do so in future projects. Data from the benchmarking showed the following:

- The trust ran the outpatient services for 12 hours on weekdays, which was above the cohort average. This was amongst the longest running services.
- The trust ran the outpatient services for eight hours on Saturdays, which was above the cohort average.
- The trust central booking team ran for 9 hours on weekdays, which was below the cohort average. The cohort average was 9.5 hours.
- 75% of requests for advice or guidance services were responded to within five days; this was above the cohort average.
- The trust reminded patients twice of their appointment before the date, this was above the cohort average. Most of the cohort did this.
- The average time taken to respond to telephone calls was 90 seconds, this was better than the cohort average.
- Apart from urology the other specialities provided shorter slot durations for new appointments when compared to the rest of the cohort.
- 96% of outpatient appointments were delivered face to face this was just below the cohort average of 97%.

Managerial staff told us that the outcome sheets were being developed to be trialled in the dermatology speciality with the outlook to eventually use in other specialities. The outcome sheets were intended to gather information on patients to feed into service improvements.

**Competent staff**

From April 2017 to November 2017, 89% of staff within outpatients at Hillingdon Hospital had received an appraisal. The trust did not provide an appraisal target rate. Medical & Dental staff had the lowest completion rate of 43%.

A split by staff group can be seen in the chart below:

<table>
<thead>
<tr>
<th>AC - Outpatients</th>
<th>No. staff required (YTD)</th>
<th>No. staff who have received an appraisal (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>11</td>
<td>11</td>
<td>100%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>9</td>
<td>9</td>
<td>100%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>21</td>
<td>21</td>
<td>100%</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>13</td>
<td>13</td>
<td>100%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>72</td>
<td>70</td>
<td>97%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>61</td>
<td>59</td>
<td>97%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>7</td>
<td>6</td>
<td>86%</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>35</td>
<td>15</td>
<td>43%</td>
</tr>
</tbody>
</table>
Managers and staff told us performance and practice was continually assessed during their mid-year reviews and end of year appraisal. Staff we spoke with confirmed they received regular appraisals.

Nursing and allied health professional staff we spoke with confirmed they were encouraged to undertake continual professional development and were given opportunities to develop their skills and knowledge through training relevant to their role. This included completing competency frameworks for areas of development. Some nursing staff told us that the new training app allowed them to book courses outside of mandatory training that may be useful to their professional role, however felt that due to budgetary constraints they could not book external courses.

New and junior staff had to complete a competency framework before being allowed to work without senior supervision. These competency workbooks were also inclusive of reception and healthcare assistant staff. The competency workbooks were based upon the job description of the role and helped the staff member conclude their probationary period.

Managers told us they had procedures in place for the induction of new staff and all staff completed hospital and departmental induction before commencing their role, apart from bank staff who only attended the departmental induction. We saw evidence of attendance at these induction sessions.

The service had 10 band five nurses, three band six nurses, five band seven nurses and four band eight nurses with post-graduate qualifications. We were told by staff and management that the trust would consider paying for staff post-graduate qualification if useful to their professional role.

**Multidisciplinary working**

Multidisciplinary team (MDT) working was evident throughout the outpatient department. We observed positive working relationships between nursing, medical and allied health professional staff. Nursing, medical and healthcare assistant staff we spoke with all told us that the department had a positive MDT approach to patient care.

One stop shop clinics were regularly conducted involving a multidisciplinary approach to diagnosing and consulting patients for specific areas of concern. The breast clinic had patients being seen by the consultant, clinical nurse specialist and having diagnostics conducted by radiographers. There were also clinics run by the dietitians in the diabetic clinic. Transition clinics was also held in some specialities, where paediatric and adult consultants carried out joint clinics to promote continuity of care for young people transitioning between children’s and adult services.

Regular consultant led MDT meetings were held to discuss patients in their respective specialties; CNS staff regularly attended these meetings. We were told by managers that nursing staff, allied health professionals and managers were encouraged to attend.

There were established links between outpatient staff and the safeguarding teams. Staff described accessing the teams for support during previous safeguarding concerns.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)
The trust was part of the North West London Pathology network which consisted of three large NHS trusts in the region working collaboratively to laboratory services for primary and secondary care.

**Seven-day services**

All specialities ran clinics every weekday most outpatient areas were open 9.00am to 6.00pm, however some specialities ran clinics from 8.00am to 8.00pm. There were also clinics that ran on Thursday evening and Saturday mornings on an as needed basis.

The outpatient pharmacy was open weekdays 9.00am to 5.30pm. Saturday dispensing was available in the mornings at the inpatient pharmacy.

**Health Promotion**

We observed that the department had various posters and information leaflets regarding national health issues such as obesity, healthy living, smoking and cancer awareness.

The ophthalmology service held regular information stalls in the main outpatient department lobby to promote the correct care of the eye and to raise awareness regarding macular degeneration. Staff we spoke with told us that these stalls did garner interest from patients and visitors allowing them to ask questions from staff.

Dermatology also held regular stalls informing patients and visitors about the dangers of sun damage, the risk of cancer and correct skin care.

The infection prevention and control team regularly held stalls around the hospital informing patients and visitors about the importance of hand hygiene.

CNS staff regularly held telephone follow-up clinics and provided their contact numbers to patients at risk of developing long term conditions. These sessions allowed patients to enquire regarding and concerns they may have and seek advice on how to manage their condition.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

Outpatient staff showed an understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with were aware of their duties and responsibilities in relation to patients who lacked capacity. The trust provided training on the Mental Capacity Act and Deprivation of Liberty Safeguards as part of their wider safeguarding training.

We observed patient consultations and witnessed patients giving verbal consent after comprehensive explanations of tests and examinations had been given by staff. Evidence of consent was present in all clinical records we reviewed during the inspection. We did not see any evidence of Deprivation of Liberty Safeguards in any of the clinical records we reviewed.

We observed that only standard consent forms were available in the outpatient clinic rooms, however nursing staff told us that if they recognised a patient that may lack capacity that they would use the correct consent forms which were stored in a separate area.
A mental health liaison team, provided by the local mental health trust, were on site 24 hours a day. All assessments for detention under the Mental Health Act were coordinated with the team from the local mental health trust.

### Is the service caring?

**Compassionate care**

Patients we spoke with consistently gave positive feedback about the care provided by nursing staff, who they described as kind and caring. Patients told us that the nursing staff were “excellent” and many patients commented that staff in general had “very good communication skills”.

All patients we spoke with that had contact with CNS staff praised them highly. All patients we spoke with in relation to CNS staff told us they felt the care provided was highly commendable.

We observed nursing, medical, healthcare assistant and allied health staff provide compassionate and considerate care to patients. All staff we observed introduced themselves and attempted to build a good rapport with patients.

The environment and the consulting rooms in the outpatients department allowed for confidential conversations.

Data provided to us in relation to the friends and family test (FFT) is as follows:

![Graph showing patient recommendations]

The above graph and table show the percentage of patients that would recommend the outpatient clinics to friends and family if they required care or treatment over the period of February 2017 to February 2018. We were not provided with response rates in relation to the above data, however during the inspection we observed more detailed FFT data which was displayed in the outpatient...
Response rates were variable every month but overall, they had risen from February 2017 to February 2018. The total number of responses over the whole period was 8356.

**Emotional support**

Nursing staff provided practical and emotional support to patients in all the clinics. Staff told us how they supported patients who had been given bad news about their condition, and offered them sufficient time and space to come to terms with the information they were given.

Patients reported that if they had any concerns, they were given the time to ask questions. Staff made sure that patients understood any information given to them before they left the clinic.

Psychological and counselling services were available for patients and their relatives. CNS staff and medical staff told us they were able to refer patients to these services if needed.

A cancer information centre operated under the franchise of a well-known charity was located within the main outpatient department. Specialist nurses employed by the trust ran the centre and provided guidance, advice and support to patients and visitors.

**Understanding and involvement of patients and those close to them**

Most patients we spoke with had positive remarks regarding medical staff; however, a significant portion of patients did tell us that their consultants were abrupt at times and they felt they were not given the opportunity to ask questions regarding their care. Some patients told us that delays in diagnostic imaging results were not properly conveyed to them and this caused anxiety.

We saw CNS staff spending time with patients, explaining care pathways and treatment plans. All patients we spoke with in one stop shop clinics told us they fully understood why they were attending the hospital and had been involved in discussions about their care and treatment.

Repeat patients we spoke with told us that they were given a contact number, usually the CNS, whom they could contact if they needed advice or guidance. These patients also mentioned that their GP’s were well informed of their treatment plans and that they regularly received letters regarding their care. All patients could receive copies of the letters sent to their GP’s if they completed a form; we observed that these forms were readily available near reception desks.

All patients and relative we spoke with highly commended the outpatient pharmacy team. Patients told us that they could contact the pharmacy from home to arrange any prescriptions or talk about medication that was given to them.

Posters were displayed in the waiting areas regarding safeguarding and abuse. Helpline numbers of charities were provided for people who may need to contact them.

FFT results and ‘you said, we did’ posters were also displayed in all waiting areas within the outpatient department.
Is the service responsive?

Service delivery to meet the needs of local people
From October 2016 to September 2017:
The ‘did not attend’ rate for Hillingdon Hospital was higher than the England average

The chart below shows the ‘did not attend’ rate over time.

Proportion of patients who did not attend appointment, The Hillingdon Hospitals NHS Foundation Trust

(Source: Hospital Episode Statistics)

The DNA rate for the above period was 9.8% data provided to us showed that this has since improved to 9.2% which is still higher than the England average. Managerial staff told us that DNA rates will continue to be addressed as part of the outpatient’s productivity work stream and will be monitored through governance meetings. They told us that the service has been increasing the use of the text reminder service.

Patients were able to book their initial appointment through the centralised choose and book system; although this allowed the patient some flexibility reception staff told us this system had its drawbacks. Patients were not able to amend their appointments with ease and this sometimes led to DNA’s. Reception staff booked all follow-up appointments in a localised system for all outpatient specialties and found this system to be more user-friendly.

Nursing staff we spoke with told us that although they felt positively regarding the text reminder service, they did not feel it was working well. This corroborated with the majority of patients that we spoke with telling us that they did not receive a text reminder. Some patients told us that they were provided an automated number to call to confirm their appointment; however, this number was not always operational.

We observed that there was adequate signposting in the outpatients and imaging departments. Hospital maps were not always located in convenient locations and were not very clear.
Patients told us they received instructions over the telephone when booking the appointments for outpatient or diagnostic appointments.

Waiting areas were generally clean; however, some areas such as ophthalmology did not have sufficient seating for busier periods. The age and layout of the building created some narrow corridors which added to the congestion and becoming difficult to wheelchair users. All waiting areas we observed had adequate access to drinking water, food, toilets and contained reading materials. Some waiting areas contained children toys.

Accessible toilets were available throughout the building and wheelchairs were available near the main entrance.

The department waiting areas were colour coded to the local specialty; this was intended to make it easier for patients to locate the correct area. Most patients we spoke with told us they did not find this system particularly noticeable as some areas were not obvious.

Information leaflets regarding various illnesses, treatments and diagnostic procedures were readily available in all waiting areas we observed.

There was sufficient car parking available with good access to outpatient facilities. Patients spoke positively regarding the recent update to parking payment system which allowed them to pay at the end of their visit. Patients we spoke with that were living with a disability told us that although they appreciated the free parking the validation method made them make multiple trips back and forth from security and this added difficulty to the lives of people who already may have mobility issues.

The hospital was located near several bus stops serving local London buses and home county buses. The hospital was not located a walkable distance from local train stations.

Specialist clinics and one stop shops clinics were conducted for specific specialties such as breast, gynaecology, diabetes etc. Other clinics ran for extended hours allowing for suitable appointment times for working patients. The service also ran Saturday morning clinics on a need to need basis. CNS staff held telephone clinics allowing for patients to raise concerns and seek advice regarding their care; patients could be fast-tracked back into a regular clinic if there was a need.

There was a multi-faith chaplaincy available for patients, relatives and staff who wished to access it. The hospital also had a Christian chapel and Muslim prayer room.

Patients had access to a volunteer run café based in the main outpatient department. The main department also had various vending machines and one 24-hour hot food vending machine. There were also other food outlets and convenience stores located in the main hospital building. Patients had access to free drinking water.

**Meeting people’s individual needs**
The service identified people’s individual needs through alerts on the administrative system and stickers were placed on the clinical records. This included alerts for learning disabilities, dementia, and interpretation.

Nursing staff told us that patients living with dementia or other mental health conditions were identified via the administrative system and this allowed nursing staff to actively manage their journey through the department. Staff would fast-track patients and ensure they were seen as soon as they arrived with minimal delay. Patients with complex needs were offered appointments in quieter periods of the day and could be accommodated to wait separately in unused clinic rooms in required.

Senior nursing staff we spoke with told us of an example when they had to assist a patient living with Tourette’s syndrome. They co-ordinated with the patient and their relatives before the appointment and found a suitable side room for the patient to wait. Staff ensured the patient and their relatives were provided with adequate food and drink and were kept informed whilst in the side room.

Some outpatient clinic room contained examination beds suitable for bariatric patients, the fracture clinic has a special bariatric bay and nursing staff told us that any further equipment could be ordered from the trust equipment library.

The hospital subscribed to an interpreting and translation service. Face to face translation and interpretation was arranged via the reception staff and we were told that this was done prior to patients arriving. For repeat patients the service always tried to ensure the same interpreter for consistency. We observed there to be leaflets and some limited hospital signage in other languages.

The hospital provided a transport service for qualifying patients. Nursing staff told us that these patients were prioritised as default within the department to ensure that they returned home in a timely manner.

The plaster clinic had bays designed specifically for bariatric patients and children. The clinic also offered all patients customisable casts where they could choose colours, patterns and add decorations.

We saw evidence of a trust chaperone policy and nursing staff told us that patients were always asked if they would like a male or female chaperone, however we did not see any posters of signs advertising this to patients.

**Access and flow**

Some specialties employed RTT co-ordinators who oversaw the patient pathway. These staff members ensured that patients remained within their targets and raised issues with the relevant area managers if patients were at risk of breaching. Staff we spoke with told us that most issues around patients nearly breaching came from diagnostic imaging as they were backlogged in referrals. Specialties held meetings where the CNS, co-ordinators, matrons and service managers would discuss patients and their RTT targets.
From December 2016 to November 2017 the trust’s referral to treatment time (RTT) for non-admitted pathways has been better than the England overall performance. The latest figures for November 2017 showed 92.8% of this group of patients were treated within 18 weeks versus the England average of 88.8%.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, The Hillingdon Hospitals NHS Foundation Trust

(Source: NHS England)

16 specialties were above the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>100.0%</td>
<td>92.7%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>99.6%</td>
<td>90.2%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>99.3%</td>
<td>93.8%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>99.2%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>98.1%</td>
<td>87.6%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>97.7%</td>
<td>95.9%</td>
</tr>
<tr>
<td>Urology</td>
<td>96.9%</td>
<td>88.1%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>95.9%</td>
<td>85.6%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>95.2%</td>
<td>92.1%</td>
</tr>
<tr>
<td>ENT</td>
<td>94.7%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Other</td>
<td>94.6%</td>
<td>91.5%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>91.2%</td>
<td>89.6%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>89.9%</td>
<td>85.3%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>89.8%</td>
<td>87.2%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>89.1%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Neurology</td>
<td>88.0%</td>
<td>82.3%</td>
</tr>
</tbody>
</table>

One specialty was below the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>81.3%</td>
<td>90.4%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Medical staff and nursing staff we spoke with in rheumatology were aware of their speciality being below the England average. They cited an overall lack of resources as the reason. Consultants explained that they were unable to follow NICE guidelines in relation to providing monthly monitoring to recently diagnosed patients, there were plans to develop nurses into leading this clinic in the future, however nurse recruitment was an ongoing issue. Staff also told us that they recently obtained approval for a new IT system which would help them manage the medication for patients and free up capacity for consultants, however this IT system was yet to be implemented.
From December 2016 to November 2017 the trust’s referral to treatment time (RTT) for non-admitted pathways has been better than the England overall performance.

**Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, The Hillingdon Hospitals NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoracic Medicine</td>
<td>99.3%</td>
<td>91.8%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>99.0%</td>
<td>96.8%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>98.8%</td>
<td>90.6%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>97.9%</td>
<td>87.8%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>97.8%</td>
<td>94.2%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>97.7%</td>
<td>91.2%</td>
</tr>
<tr>
<td>ENT</td>
<td>97.2%</td>
<td>88.4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>95.5%</td>
<td>90.1%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>92.1%</td>
<td>91.4%</td>
</tr>
<tr>
<td>Neurology</td>
<td>91.5%</td>
<td>88.8%</td>
</tr>
<tr>
<td>Other</td>
<td>91.3%</td>
<td>91.2%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>91.3%</td>
<td>86.1%</td>
</tr>
<tr>
<td>Urology</td>
<td>90.0%</td>
<td>88.2%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>89.4%</td>
<td>86.4%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>86.2%</td>
<td>84.1%</td>
</tr>
</tbody>
</table>

No specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

*(Source: NHS England)*

The trust is performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

**Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), The Hillingdon Hospitals NHS Foundation Trust**
The trust is performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.

**Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), The Hillingdon Hospitals NHS Foundation Trust**

(Source: NHS England – Cancer Waits)

The trust is performing better than the 85% operational standard for patients receiving their first definitive treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

**Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, The Hillingdon Hospitals NHS Foundation Trust**

(Source: NHS England – Cancer Waits)

Nearly all patients we spoke with complained about the waiting times for clinics. Some patients we spoke with during inspection were waiting more than one hour. We observed that delays were
always relayed to patients via notice boards or verbally and patients we spoke with corroborated this.

The service did not regularly audit waiting times for patients to be seen once they arrived in the department; however, we were provided with data to show an audit of two random weeks in January 2017 and March 2017. The data for March 2017 showed that every clinic in the department at some point in the week had a delay more than 45 minutes and delays of over 60 minutes were not uncommon. The highest delay in the data was of 185 minutes. The most common reason for delays was the clinics being overbooked and complex patient consultations.

Learning from complaints and concerns
From November 2016 to November 2017 there were 53 complaints about outpatients. The trust took an average of 38 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed in 30 days.

The most prevalent subject matters were:
- Appointments, delay/cancellation (out-patient) – 20 (38% of complaints)
- Attitude of staff – six (11% of complaints)

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Staff we spoke it told us that they were encouraged to deal with complaints locally in the first instance and refer to their area leads or matrons if needed. Complaints leaflets and PALS information was readily available in all outpatient areas. Formal complaints were received by the centralised complaints department who would send the complaint to the suitable division for investigation. Managers told us that complaints were discussed in divisional and local team meetings. Complaints were investigated and reported on by the outpatient department or the central team based on the seriousness and patients were provided with the outcome.
Is the service well-led?

Leadership
The outpatient services were part of the cancer and clinical support services division. The division was led by a divisional director who was supported by an assistant director of nursing and an assistant director of operations. The divisional leads reported to the chief operating officer who in turn reported to the CEO.

Within the division the senior matron, lead dietitian, lead cancer nurse, various CNS’s, booking manager, business and service manager, radiology lead clinician, radiology service manager, pathology manager, therapies manager and chief pharmacist all reported to the divisional leads.

Within the main outpatient department, the healthcare assistant staff and band five nurses were line managed by the band six lead nurses for each specialty. The band six nurses handled all managerial duties including annual leave, sickness and appraisals. The band sixes were supported by the matrons when required. The service had recently appointed a new outpatient lead band seven nurse whose role was still in development, managerial staff told us that eventually the band seven role would be a deputy to the matron role and would be expected to supervise multiple areas of the outpatient department. The band seven lead nurse was supervising main outpatients and line managing staff in the area at the time of the inspection. The band six and band seven nurses reported to the outpatient matrons. The outpatient matrons reported to the senior outpatient matron.

Nearly all staff we spoke with across all outpatient areas we visited commented that they felt that local leaders were approachable and that they felt comfortable raising issues with their immediate line managers. Nursing staff spoke positively of their lead nurses and matrons; they told us matrons made regular visits to all speciality areas. The majority of outpatient staff told us that they felt the divisional leads were not visible enough and did not feel comfortable to approach them, some junior staff told us that they would be unable to recognise the divisional leads. All staff we spoke with told us that trust executives walk rounds were very rare and apart from the CEO they would be unable to recognise other executives.

The divisional leads felt they had a voice at the trust board and that executive leadership supported them well. Matron staff also praised their divisional leads citing an example of supporting one matron in expanding the role and taking on more clinical duties.

Junior nurses told us they felt well supported by their senior nurses and they felt they could discuss issues openly with matrons as well. Senior nurses felt that matrons were overall were supportive and helpful, however issues the seniors raised around staffing, managerial duties and other issues are not properly addressed.
There was also a sentiment amongst all senior nurses we spoke with that their managerial duties were too excessive for their pay band. Senior nurses told us that they felt they were struggling completing both managerial and clinical duties especially in times of staff absences. Managers told us that lead nurses were expected to prioritise clinical needs and during instances where appropriate bank staff was unable to be sourced that lead nurses would have to fill in, however lead nurses were able to call matrons to support in duties.

**Vision and strategy**

The trust vision was “to be an outstanding provider of healthcare through leading health and academic partnerships, transforming services to provide better care when needed”. This was underpinned by the trust CARES values which stood for communication, attitude, responsibility, equity and safety.

The values were developed with patients and described the behaviours they and the trust expected from staff. Staff we spoke with knew and understood the trust vision and values and had a sense of their roles in exhibiting the values in their work.

Managerial staff explained to us that departmental goals and strategies were formed by the input of divisional leads and local staff. Local managers would discuss issues and goals with frontline staff in team meetings and this would be fed back to the divisional team.

Managerial staff told us that they were focussed on developing their nurses and assistant staff to provide a greater job satisfaction; this included embedding the new band seven lead nurse into the departmental structure. Divisional leads told us that they aimed to streamline the departmental IT systems for them to be more efficient and user friendly.

The managerial staff mentioned that the divisional and departmental strategies and goals were set out in a business plan for the upcoming financial years. We requested this information, however we did not receive it.

**Culture**

We found a positive and inclusive working culture within the outpatient services at the hospital, all clinical and administrative staff we spoke to were passionate about achieving the best for patients. Staff we spoke with described a supportive and patient orientated environment and said they felt valued by their colleagues.

Leaders of the service were proud of their staff and highlighted their efforts and contribution to the department and high standard of care for patients. Managers told us that there was a high rate of staff returning to work at the hospital who had previous left to work elsewhere and they felt that this was indicative of the positive working culture.

Nurses we spoke with told us there was a supportive, respectful and positive working atmosphere and that there were good relationships with colleagues from different disciplines and levels of seniority. Some nursing staff told us that the department was slow to adopt newer working practices and that it took great effort to gain support for innovation.
Consultant doctors told us there was a supportive culture among clinicians and an open approach to challenge and peer review.

The trust made use of ‘Greatix’ for staff to report and share when their colleagues had gone above and beyond.

**Governance**

There were effective general governance structures in place in the outpatient department. There were regular staff meetings which provided a forum for staff to share their views or concerns with managers. Staff and managers, we spoke with felt that governance structures were effective.

Matrons from the outpatient department attended monthly divisional governance meetings. These meetings discussed incidents, learnings, complaints, key performance indicators, issues pertaining to different departments within the division. Information from these meetings were disseminated to general staff via the monthly departmental team meetings.

Governance and performance information was shared with staff in a monthly newsletter available via the trust intranet.

Nursing, medical and assistant staff were clear on their professional role and responsibility. We found there to be overlap in roles and responsibility within the nursing seniority in the outpatient department. Divisional leads and the matrons were not clear on the full extent of the new band seven lead nurse role and senior nurses felt their managerial duties were excessive of their pay band.

We had concerns regarding laser governance as the trust had been operating its laser service without a laser protection advisor as per the MHRA best practice guidance. The local rules were not in a complete state during the inspection and were not written by the laser protection advisor. There were no laser safety audits and the laser safety committee did not meet in a regular capacity until recently. The trust did not hold accurate information to the number of lasers present in the hospital or their strength.

**Management of risk, issues and performance**

There were five main risks present of the divisional risk register. The risk that scored the highest was associated with the overcrowding in the ENT and eye clinic waiting rooms, the mitigating actions the trust was implementing was staff informing patients of vacant seating in another waiting area, fast tracking patients with disabilities and staff to ensure correct identification checks are made after the patient has been called.

Other moderate risks present were to do with the department layout being open plan and this did not allow ideal privacy and dignity, refurbishment of the sound proof rooms made it an unsuitable environment for audiology testing, VTE assessments were not always re-done within 24 hours and finally the environment where eye tests were undertaken being very cramped.
These risks ranged between three to eight years old, however some of these risks were on other divisional risk registers applying broadly across the hospital and some were to do with the physical building.

The issues and risks which managers identified were in line with what we found on inspection and there was alignment between these and the risks outlined on the risk register, except the risks associated with the laser service which were not present on the divisional risk register or the trust health and safety risk register.

The risk register was discussed at clinical governance meetings for each specialty and at divisional level.

**Engagement**
Senior nurses told us that public engagement was limited to gathering and analysing responses to the Friends and Family Test (FFT). They told us that the trust previously implemented an outpatient questionnaire via tablets which we observed in the corridors, however the agreement between the company which processed the data had expired and was not renewed.

The department hosted student nurses from a local university and actively sought feedback after the student completed their work placements. The feedback shown to us was positive with some student citing outpatients being the most enjoyable of their time in the hospital.

There was regular trust and departmental communication through newsletters, staff emails and regular team meetings. Managerial staff told us that staff were free to raise concerns and issues with line managers or during these staff meetings.

We requested detailed information on any staff feedback surveys which may have been conducted, however we did not receive this information.

**Learning, continuous improvement and innovation**
Some nursing staff we spoke with told us that the department was slow to adopt new working practices and that it took great effort to gain support for innovation. Managerial staff told us of some examples of new practices the department had adopted since the previous inspection.

Safety huddles had been recently implemented throughout the department, these huddles were designed so teams could discuss events, incidents and care plans before the start of the clinic and set individual staff responsibilities for specific tasks. This ensured that the team was working cohesively.

The ones stop shop clinics that were conducted in gynaecology and the breast clinic allowed patients to be seen by a consultant, CNS and have diagnostic procedures done in the same day. There were plans to further implement this system in dermatology.

Telephone assessments and clinics run by CNS staff for their various specialities, these allowed patients to raise concerns and seek advice specific to their care needs and if needed be fast tracked back to hospital.
The new outpatient pharmacy was opened recently with a renovated waiting area and text alert system for patients.

Managerial staff were also proud of the ophthalmology service which took part in many clinical trials and was in the process of hiring specific pharmacy staff to assist in their trials.

The new band seven lead nurse created a staff bulletin for outpatients. The bulletin was released monthly and included details on the latest outpatient news, innovations, useful information for staff to know and professional awareness days. Junior nursing staff we spoke with told us they found the bulletin useful.