

# North West London Hospitals NHS Trust

## Northwick Park Hospital

### Quality Report

Watford Road  
Harrow  
Middlesex  
HA1 3UJ  
Tel: 020 8864 3232  
Website: [www.nwlh.nhs.uk](http://www.nwlh.nhs.uk)

Date of inspection visit: 20-23 May 2014  
Date of publication: 20/08/2014

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

### Ratings

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

# Summary of findings

## Letter from the Chief Inspector of Hospitals

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

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

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

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

Our key findings were as follows:

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

We saw an area of outstanding practice:

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

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

Importantly, the trust must:

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

# Summary of findings

In addition the trust should:

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

**Professor Sir Mike Richards**

**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Accident and emergency

Requires improvement

### Rating



### Why have we given this rating?

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

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

#### Medical care

Good



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

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

#### Surgery

Requires improvement



The surgical service at Northwick Park Hospital requires improvement. Whilst the day-to-day running of the department generally provided safe care, the service faced notable risks. The low number of middle grade doctors and the low number of general surgical lists meant that there

# Summary of findings

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

## Critical care

### Inadequate



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

## Maternity and family planning

### Requires improvement



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

# Summary of findings

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

## Services for children and young people

Requires improvement



Services for children and young people at Northwick Park Hospital require improvement. Children received effective care from staff trained to work with children. Staff engaged well with children of different ages. The facilities were generally good, particularly in the day care/children's outpatient area. Staffing and skill mix on the ward, the neonatal unit and the day care/outpatient service were sufficient.

However, there was insufficient space for storage of equipment on the children's ward, and some areas were cluttered.

Parents had confidence in the care their children received, and spoke positively about staff's compassion and communication. We observed staff showing care and responsiveness to individual children. However, we found some areas where safety needed to be strengthened, such as ensuring clinical equipment was not accessible to children on the inpatient ward, and that medical equipment was serviced annually.

There were arrangements to meet the diverse language needs of the population served by the hospital. However, there was a lack of joined up working across the medical team and between doctors and nurses. We also found that the service itself was distant from the trust board. There were no processes to obtain the views of the service from families and friends, although we were told that some ideas were being considered.

## End of life care

Good



We found that the end of life care to patients was good overall. The hospital had good links with the specialist palliative care team (SPCT) and community services, in order to support patients and their families. The SPCT and other services involved in end of life care were passionate, caring and maintained patients' dignity throughout their care. There was clear multidisciplinary involvement in patient care. Patients were involved in advance

# Summary of findings

care planning and their preferences were observed and followed through when possible and appropriate. People's cultural and religious needs were taken into account.

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

## **Outpatients**      **Requires improvement**



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

Patient notes for the individual clinics were kept in open trolleys and we saw that on occasions, these were left unsupervised. The lack of secure storage meant there was the possibility of confidentiality being breached.

Clinicians took sufficient time in consultations, and patients said that they felt involved in their care. The demand for some of the clinics was greater than the capacity. This meant that some clinics ran late and also had long waiting times for appointments. There were initiatives in place to consider moving some services to improve their efficiency.

**Requires improvement** 

# Northwick Park Hospital

## Detailed findings

### Services we looked at

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

## Contents

Detailed findings from this inspection	Page
Background to Northwick Park Hospital	9
Our inspection team	9
How we carried out this inspection	9
Facts and data about Northwick Park Hospital	10
Our ratings for this hospital	12
Findings by main service	13
Outstanding practice	76
Areas for improvement	76
Action we have told the provider to take	77

# Detailed findings

## Background to Northwick Park Hospital

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

Northwick Park Hospital is in the London Borough of Harrow, and lies to the north-western outer ring of Greater London bordering on the county of Hertfordshire. The population of Harrow is 239,056 as recorded in the 2011 Census. The GP registration data shows that the percentage of the population registered with a GP in Harrow is 96.2%. Of 326 local authorities, Harrow is the

194th most deprived. In Harrow, 57.8% of the population belong to non-White minorities. Of these, the Asian ethnic group constitutes the largest ethnic group with 42.6% of the population.

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

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

## Our inspection team

### Our inspection team was led by:

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

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

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

## How we carried out this inspection

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

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

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

- Accident and emergency (A&E)
- Medical care (including older people's care)

- Surgery
- Intensive/critical care
- Maternity and family planning
- Services for children and young People
- End of life care
- Outpatients

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

# Detailed findings

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

We talked with patients and staff from various areas of the hospital including the wards, theatre, outpatients

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

## Facts and data about Northwick Park Hospital

### Key facts and figures about the trust

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

### Intelligent Monitoring

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

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

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

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

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

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

### Individual Elevated Risks

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

### Individual Risks

- 'Never event' incidence

- Potential under-reporting of patient safety incidents
- PROMs EQ-5D score: Knee Replacement (PRIMARY)
- Proportion of patients who received all the secondary prevention medications for which they were eligible
- Maternity Survey 2013 C14 "If you raised a concern during labour and birth, did you feel that it was taken seriously?" (Score out of 10)
- Maternity Survey 2013 C18 "Thinking about your care during labour and birth, were you treated with respect and dignity?" (Score out of 10)
- Healthcare Worker Flu vaccination uptake

### Safe:

Never events in past year - 4

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

National Reporting and Learning System (NRLS)

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

### Effective:

HSMR - No evidence of risk

SHMI - No evidence of risk

### Caring:

CQC inpatient survey - **average**

Cancer patient experience survey - **below**

### Responsive:

Bed occupancy - 92.9%

Average length of stay - \_\_\_\_\_

A&E: 4 hour standard - Elevated Risk

# Detailed findings

Cancelled operations - No evidence of risk

Delayed discharges - No evidence of risk

18 week RTT - Elevated Risk

Cancer wards - No evidence of risk

## Well-led:

Staff survey - **average**

Sickness rate 2.9 % - **above**

GMC training survey - **below**

# Detailed findings

## Our ratings for this hospital

Our ratings for this hospital are:

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

### Notes

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

# Accident and emergency

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

## Information about the service

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

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

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

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

## Summary of findings

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

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

# Accident and emergency

## Are accident and emergency services safe?

Requires improvement



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

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

### Incidents

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

### Cleanliness, infection control and hygiene

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

### Environment and equipment

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

# Accident and emergency

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

## Medicines

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

## Records

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

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were knowledgeable about how to support patients who lacked capacity. They were aware of the need to assess whether a patient had a temporary or

permanent loss of capacity, and how to support patients in each situation. If there were concerns regarding a patient's capacity, staff ensured that the patient was safe and then undertook a mental capacity assessment.

- According to the A&E mandatory training database, all nursing and medical staff had undertaken training on the Mental Capacity Act.
- We observed nursing and medical staff obtaining consent from patients prior to any care or procedure being carried out.

## Safeguarding

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

## Mandatory training

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

## Management of deteriorating patients

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

# Accident and emergency

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

## Nursing staffing

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

## Medical staffing

- The A&E department had six WTE consultants during our inspection. They were present in the department from 8am until 10pm. There were middle grade and junior doctors on duty overnight, with an on-call consultant system in operation.
- There was a high use of locum middle grade doctors, and the senior management team were aware of this. This was particularly true at weekends and out of hours. The doctor's rota showed that the locum middle grade

doctor use was inconsistent. This meant that the hospital was not using the same doctors who had received the trust induction programme and were familiar with the department and protocols.

- The A&E department had a vacancy for a clinical lead and was, at the time of our inspection, recruiting to the post. There was no clinical director for the A&E department at Northwick Park Hospital.

## Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

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

## Evidence-based care and treatment

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

## Care plans and pathway

- There were clear protocols for staff to follow with regards to the management of stroke, fractured neck of femur, and sepsis. The department had introduced the 'Sepsis Six' interventions to treat patients. 'Sepsis Six' is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis.

# Accident and emergency

- Nurses at the A&E department at Northwick Park Hospital no longer obtained blood cultures from patients who were suspected to be septic, as this was now done by medical staff. A consultant told us that this had not resulted in any significant delay in patients receiving antibiotics who may be suffering from sepsis.

## Nutrition and hydration

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

## Patient outcomes

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

## Competent staff

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

## Multidisciplinary team working

- We witnessed comprehensive multidisciplinary team (MDT) working within the A&E department. Medical and nursing handovers were undertaken separately. Nursing handovers occurred twice a day, and staffing for the shifts was discussed, as well as any high risk patients or potential issues. Medical handovers occurred twice a day and were led by a consultant.
- There was a clear professional conjoined working relationship between the A&E department and other

allied healthcare professionals within other departments. An example of this was the Short Term Acute Rehabilitation and Re-enablement Service (STARRS). The STARRS service consisted of therapists and nurses who visited the A&E department daily to provide intervention from community services, enabling patients to be discharged home with an appropriate care package and support.

- Staff we spoke with were aware of the protocols to follow and key contacts within external teams. We witnessed staff being professional towards patients during their transition from the care of the ambulance service to the A&E staff.
- The hospital's psychiatric and alcohol team could be accessed to support appropriate patients. Although the department did not collect data with regards to their input, the service was available when required.

## Seven-day services

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

## Are accident and emergency services caring?

Good



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

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

# Accident and emergency

## Compassionate care

- We witnessed multiple episodes of patient and staff interaction, during which staff demonstrated caring and compassionate attitudes towards patients.
- The trust was performing significantly worse than the England average in the NHS Friends and Family Test within the A&E department in January and February 2014.
- Staff were knowledgeable about the care pathways available to benefit their patients.

## Patient involvement in care

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

## Emotional support

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

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

Requires improvement



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

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

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

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

## Access and flow

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

# Accident and emergency

admissions via the A&E department waiting 4-12 hours from the decision to admit until being admitted. In February 2014, the trust was performing at 15%, with the England average being 6%.

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

## Meeting people's individual needs

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

## Learning from complaints and concerns

- The A&E department promoted the Patient Advice and Liaison Service (PALS) which was available in the hospital. Information was available for patients on how to make a complaint and how to access the service.
- All concerns raised were investigated by staff, and there was a centralised recording tool in place to identify any trends emerging.
- We were told that learning from complaints was not disseminated to the whole team in order to improve the

patient experience within the department. Root cause analyses of complaints were not carried out and we were told that this was due to there being so many complaints, that it caused 'complacency' amongst staff.

## Are accident and emergency services well-led?

Requires improvement



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

## Vision and strategy for this service

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

## Governance, risk management and quality measurement

- Monthly departmental meetings were held. We were provided with the minutes of the meetings held over the past six months. Top risks were discussed, including what was being done to mitigate the risks.

# Accident and emergency

- A quality dashboard was available within the A&E department. However, it was displayed in a back corridor and had no information displayed on the board. We spoke with staff about quality indicators and there was a lack of demonstrable knowledge about it.

## **Leadership of service**

- There was a strong departmental team, which was respected and led by the senior nurses.
- The senior management team were interviewed separately, and the conclusion drawn from the interviews was that the leaders' visions were not cohesive and, at the time of the inspection, there was a lack of joint ownership of the issues faced by the department.

## **Culture within the service**

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

## **Innovation, learning and improvement**

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

# Medical care (including older people's care)

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

## Information about the service

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

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

## Summary of findings

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

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

# Medical care (including older people's care)

## Are medical care services safe?

Requires improvement 

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

### Incidents

- The trust had been identified as a low reporter of incidents to the National Reporting and Learning System (NRLS). Medical specialities accounted for 47 incident reports, the majority (30) were rated as moderate harm, 12 as abuse, four as severe and one death.
- The trust used an electronic incident reporting system to report incidents. Staff described this system as 'cumbersome'; however, they were knowledgeable about the types and categories of incidents.
- Nursing and allied health professional staff confirmed that they were encouraged to report any incidents, and saw it as a positive way to drive learning and improvement for patients and practice.
- Staff gave us a demonstration of the process followed to report an incident, and provided examples of changes in practice. On one ward, following a patient transferring in with an undisclosed pressure ulcer, a full documented check of the patient's pressure areas with the accompanying nurse had been implemented.
- Medical staff told us that they were 'disillusioned' with the electronic incident reporting system, as they did not receive a response after they had used it to report

incidents. We were told that a number of trust grade doctors (clinical fellows/locums) did not have access to the system, and were not aware of how to report incidents.

- However, other staff members reported that they received feedback after reporting incidents, from the ward managers or matrons, and in some cases, the manager of the electronic incident reporting system. A number of staff told us that in the week prior to the inspection that they had started to receive an acknowledgement email, informing them that the incident was being investigated, and the name of the person who was carrying this out.
- Matrons confirmed that incidents were discussed with managers at directorate and nursing meetings. The matrons were also required to submit a monthly quality report to the director of nursing.
- Consultants told us that mortality and morbidity meetings were held in some specialities, but not all. These meetings did not always consist of a junior doctor.

### Safety thermometer

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

# Medical care (including older people's care)

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

## Cleanliness, infection control and hygiene

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

## Environment and equipment

- Wards visited were, in the main, uncluttered, and staff and patients had sufficient room to move around unhindered so that care could be delivered safely.

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

## Medicines

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

## Records

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

# Medical care (including older people's care)

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

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

## Safeguarding

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

## Mandatory training

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

## Management of deteriorating patients

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

## Nursing staffing

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

# Medical care (including older people's care)

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

## Medical staffing

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

- Ward rounds and 'ward board' rounds took place regularly throughout the day amongst the MDTs.

## Major incident awareness and training

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

## Are medical care services effective?

Good



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

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

## Compassionate care

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

# Medical care (including older people's care)

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

## Patient understanding and involvement

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

## Emotional support

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

## Are medical care services caring?

Good



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

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

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

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

## Access and flow

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

# Medical care (including older people's care)

ward. Staff told us that the high number of admissions did not always allow the arrangement to work effectively, and therefore patients were allocated to any available bed or remained in AAU.

- The trust had established the STARRS team, to co-ordinate and provide support to discharge patients safely. Discharge arrangements were documented in multidisciplinary patient care plans. One patient did raise concerns about their previous discharge, and the lack of information and follow up provided following admission for a cardiac problem.
- The trust had an established discharge lounge to accommodate patients who were ready for discharge and waiting for transport within a 180 minute timescale. This allowed beds to be vacated earlier and allowed more timely transfers across wards.
- A number of patients told us that they were moved "during the night" in order to "free up a bed".

## Meeting people's individual needs

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

## Learning from complaints and concerns

- The trust had signs displayed across its premises advising people on how to raise concerns, and these included the contact details of the chief executive.
- Leaflets and posters advertising the Patient Advice and Liaison Service (PALS) were seen in all areas.
- The trust used 'patient stories' to aid learning and improve the patient experience across the wards.
- Matrons and ward managers told us that they carried out daily ward rounds to pick up issues and manage them in a timely way.

- The nursing KPIs recorded the number of PALS issues or complaints across the medical wards.
- Directorate managers provided information to show that the number of complaints had decreased, despite a spike during December 2013 and January 2014. The main theme of complaints was related to discharge, particularly patient choice of where they were to be discharged, but this was usually dictated by the financial parameters of the local authority and clinical commissioning group (CCG).

## Are medical care services responsive?

Good



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

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

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

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

## Access and flow

- The trust told us that bed occupancy was very high, running at levels of 96-98% against a national average of 85.9%. It was generally accepted that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital (Dr Foster Intelligence).
- The majority of medical patients were admitted through A&E via the AAU and SSAU. This meant that patients were admitted to a short stay ward when they potentially required a longer period of stay. Patients

# Medical care (including older people's care)

who suffered a stroke were reviewed and transferred to the stroke unit for thrombolysis. The unit had been recognised as having the best response times in London.

- Data provided by the trust showed that between 1 January and 20 May 2014, the numbers of medical outliers on surgical wards ranged between 8 and 43 patients.
- The trust had set up buddy arrangements between medical and surgical wards, with patients from the respective specialties accommodated on their buddy ward. Staff told us that the high number of admissions did not always allow the arrangement to work effectively, and therefore patients were allocated to any available bed or remained in AAU.
- The trust had established the STARRS team, to co-ordinate and provide support to discharge patients safely. Discharge arrangements were documented in multidisciplinary patient care plans. One patient did raise concerns about their previous discharge, and the lack of information and follow up provided following admission for a cardiac problem.
- The trust had an established discharge lounge to accommodate patients who were ready for discharge and waiting for transport within a 180 minute timescale. This allowed beds to be vacated earlier and allowed more timely transfers across wards.
- A number of patients told us that they were moved "during the night" in order to "free up a bed".

## Meeting people's individual needs

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

## Learning from complaints and concerns

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

## Are medical care services well-led?

Good



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

## Vision and strategy for this service

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

# Medical care (including older people's care)

## Governance, risk management and quality measurement

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

## Leadership of service

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

pressure to attend work when feeling unwell, good communication with senior managers, ability to contribute towards improvement at work and motivation at work.

- The trust was rated as worse than expected or tending towards worse than expected for 12 of the 28 NHS 2013 staff survey key findings. Issues included support from immediate managers, appraisals, discrimination and equal opportunities for staff, as well as staff witnessing potential errors and near misses.

## Culture within the service

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

## Public and staff engagement

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

## Innovation, improvement and sustainability

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

# Surgery

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

## Information about the service

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

## Summary of findings

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

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

# Surgery

## Are surgery services safe?

Requires improvement 

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

### Incidents

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

### Safety thermometer

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

### Cleanliness, infection control and hygiene

- The department undertook regular audits of the standards of infection control. This included aspects of care such as MRSA screening and hand hygiene. In

general, the department was compliant with these standards, and the results were presented in a manner that would enable staff to address isolated issues that arose.

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

### Environment and equipment

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

### Medicines

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

### Records

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

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

### Safeguarding

- There was a safeguarding policy and procedure in place.

# Surgery

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

## Mandatory training

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

## Management of deteriorating patients

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

## Nursing staffing

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

## Medical staffing

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

## Major incident awareness and training

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

# Surgery

## Are surgery services effective?

Requires improvement 

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

### Evidence-based care and treatment

- There were a team of consultants who sent out bulletins each month on any new NICE guidelines that had been published. In addition, specialist nurses (such as Tissue Viability Nurses) provided specific guidance to staff on any developments in their field. Clinical developments were discussed at handovers.
- Standard risks assessments were used to evaluate patients, and ensure that they were safe whilst within the department. These included the Waterlow assessment to check for risks of pressure ulcers and the MUST nutritional screening tool. There were also specific assessments, undertaken to ensure that people were fit and well enough to undergo surgery, which followed national guidelines.
- We looked at a wide number of clinical protocols within the department that related specifically to the care and treatment of patients, such as emergency transfer protocols, analgesia guidelines and fluid management. All of these were out of date, and in the case of the post-operative fluid management guidance, contravened more recent guidance. We were concerned that new students and nurses might be referred to these guidance documents to answer any questions that they may have.
- However, we also looked at the operational protocols within the surgical admissions unit that had been opened approximately one year earlier. There were appropriate guidelines for admission, escalation, and the appropriate treatment of specific conditions. Staff reported that the unit had helped to ease the pressure on the hospital's A&E department.
- Staff undertook audits and checks on medical early warning score charts and malnutrition universal

screening tool (MUST) charts to ensure that they had been completed appropriately. Staff were able to describe the actions they had taken to improve the completion rate of MUST charts in response to the outcome of one of these audits. They also told us that fluid charts were being redesigned after an audit had found that they were not being completed correctly.

### Pain relief

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

### Nutrition and hydration

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

### Patient outcomes

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

# Surgery

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

## Competent staff

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

## Facilities

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

## Multidisciplinary working

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

## Are surgery services caring?

Good



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

## Compassionate care

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

## Patient understanding and involvement

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

## Emotional support

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

## Are surgery services responsive?

# Surgery

Requires improvement

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

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

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

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

## Access and flow

- Staff reported that the introduction of the Surgical Assessment Unit (Fletcher Ward) had made a positive difference to waiting times and to patient flow through the hospital.
- On some occasions, a lack of beds available on wards meant that patients spent the night in the recovery room, which delayed the morning surgical lists.
- Discharge planning started pre-admission, or on admission, and would involve numerous professionals, including occupational therapists and social services where appropriate. Discharge plans were monitored as part of the daily handover.

- There was a specific risk assessment to be completed before patients were discharged. This looked at what the needs of the patient were, the plans needed to be made, and the resources to be put in place before they were discharged.
- Staff reported that due to the low numbers of medical staff, patient discharge could be delayed as they waited for a doctor to sign for the medicines that they were to take home with them.
- Staff spoke positively of the discharge planners and how they supported patient arrangements to go home.

## Meeting people's individual needs

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

## Learning from complaints and concerns

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

## Are surgery services well-led?

Requires improvement

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

# Surgery

## **Vision and strategy for this service**

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

## **Governance, risk management and quality measurement**

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

## **Leadership of service**

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

## **Culture within the service**

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

## **Public and staff engagement**

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

## **Innovation, improvement and sustainability**

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

# Critical care

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

## Information about the service

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

## Summary of findings

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

# Critical care

## Are critical care services safe?

Requires improvement 

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

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

### Incidents

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

### Safety thermometer

- Staff monitored the safety of the department using a 'safety thermometer', whereby the number of patient falls and pressure ulcers (amongst other indicators) were monitored. At the time of the inspection no significant safety issues were highlighted by this tool. The results were displayed on the units.

- However, the quality assurance and clinical governance within the department was poor. As such, little other information was systematically collected about the performance of the department to ensure that it was safe. This included data about unplanned extubations, readmissions and mortality.

### Cleanliness, infection control and hygiene

- Staff reported that infection control audits took place on a regular basis, and we saw evidence of this. This included monitoring the number of healthcare-associated infections of patients, as well as compliance with hand washing protocols and the general cleanliness of the department's environment. We reviewed this data and noted that the number of infections was low.
- During the inspection, the clinical areas we visited were clean and tidy. We observed staff adhering to infection control policies and procedures, such as the use of personal and protective equipment (gloves, aprons, etc.) and hand washing. However, it was noted that in a recent audit compliance with hand washing protocols was low (69% of opportunities taken to wash the hands of staff).
- The infection control policy was not readily accessible to all staff.

### Environment and equipment

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

### Medicines

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

### Records

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

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

# Critical care

## Safeguarding

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

## Mandatory training

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

## Management of deteriorating patients

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

## Nursing staffing

- Nursing levels were based upon Royal College of Nursing and the British Association of Critical Care Nurses guidelines.
- There was a high proportion of senior grade nurses (65% at band six or seven), with 35% at band five.
- New nursing staff would be supernumerary for their first month so that they could learn about the service.
- We looked at previous rotas, which confirmed that the planned nursing staff levels were maintained over time. However, it was considered that the number of support staff, such as housekeepers or healthcare assistants, was lower than expected for the number of beds in the department.
- We observed a staff handover where an electronic handover tool was used to good effect.
- At the time of the inspection there had been a 22% uplift in the staffing budget to cover for staff on maternity leave in the department.

## Medical staffing

- Nursing staff we spoke with were positive about medical staff attending when they were needed.
- An outreach team operated throughout the hospital 24 hours a day five days a week, and 12 hours a day at weekends.
- However, in general, medical staffing levels were very low. A large number of positions were filled by locums

and clinical fellows. The trainees in the department were very junior and unable to take on many tasks independently. Whilst the number of consultants on the wards was appropriate to the number of beds and acuity of patients, because of the lack of junior grades they undertook tasks more suited to senior registrars. There had been no clinical lead in the department for the previous 12 months, although it was noted that a clinical lead had been appointed the week prior to the inspection. As a result of these low medical staffing numbers, the workload for consultants was considered to be excessive.

## Major incident awareness and training

- There was a process in place for managing an increase in the number of patients and how this was to be escalated, which was utilised by staff on a regular basis.

## Are critical care services effective?

Inadequate



Whilst nursing staff received the supervision and support whilst new on the unit the medical staff did not. A large number of locums were used to ensure adequate medical staff were available however there were no medical policies or procedures for staff to follow. This meant that patients could be getting significantly different levels of care from the doctors who treat them as there is no guidance to follow. The trust did not, during the time of the inspection, subscribe to a national audit of the intensive care services. While this is not a requirement, the trust should have a process in place to assess and monitor the quality of the service it delivers. However, only very limited information was collected on patient outcomes on the units under the NW London audit programme. On some occasions, patients were discharged before they were well enough and therefore had to be readmitted. This was particularly evident for patients admitted to the St Mark's Hospital.

## Evidence-based care and treatment

- Staff used the national early warning scores system to monitor the condition of patients. They used industry standard risk assessments, such as the Waterlow pressure ulcer tool and the MUST (Malnutrition Universal Screening Tool) system.
- There were trust-wide policies available on the intranet, which provided general guidelines on providing nursing

# Critical care

care, and these were mainly up to date. However, there were very few protocols for medical staff. For instance, there were no protocols on important aspects of critical care such as sedation, management of septic patients or renal replacement therapy. This posed a risk of inconsistent or inappropriate care and treatment of patients. In addition, because these protocols were not in place, senior staff were very limited in what treatment they could delegate to junior medical staff to carry out, and had to treat patients themselves.

- Nursing staff undertook some audits such as the NW London audit, which included the activity of the outreach team and on late discharges, but the outcomes of these were not available at the time of the inspection. They also told us that they collected the Critical Care Minimal Data Set, but evidence of this was not available either.
- Very little reliable information was collected on the activities and treatment outcomes for medical staff. The trust was not a member of the Intensive Care National Audit and Research Centre (ICNARC) and did not participate in their audits. As such, their performance was not nationally benchmarked. The trust was however, a member of the North West London Critical Care Network, which was a group of local hospitals who audited their own work according to their own criteria, and then benchmarked this against each other. This did include some of the data that would be collected by ICNARC. In addition, for at least the year prior to the inspection, this data had not been systematically collected by the trust. As such, staff were unable to tell us key information about their performance and the outcomes of their treatment. They were unable to measure their performance against local or national standards.

## Pain relief

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

## Nutrition and hydration

- We reviewed the records of six patients across the trust. Nutrition and hydration risk assessments had been completed where appropriate. Fluid balances were recorded on a daily basis, and there were daily nursing evaluations of nutrition and hydration. There were records of the involvement of a dietician where appropriate.

## Patient outcomes

- Due to the lack of reliable information collected on a consistent basis, it was unclear what the outcomes of treatment for patients were.

## Competent staff

- Nursing staff begin working in the department as supernumerary for the first month, so that they can learn about the department. Staff were supervised on a regular basis.
- The nursing staff members that we spoke with said that they felt well supported. They said that they had time to attend their mandatory training and that they had annual appraisals on their performance.
- However, medical staff's development was not similarly supported. Due to the lack of middle grade doctors and the junior nature of the trainees, workloads were very high, particularly for consultants. Some staff did note that this meant they had extensive and varied caseloads. However, due to the staff shortages, consultants reported that they were working as senior registrars and had very little time for teaching or training. This was compounded by the lack of protocols and procedures, which meant they were unable to free some of their time through delegation.
- Trainees reported that they were given time off to attend courses.
- Medical locums were used extensively throughout the department. The quality of the locums was described by staff as variable. In addition, not all locums had access to the computer system, so they were reliant on other medical staff being present for some of their duties.

## Facilities

- The pressure on the CCU department was noted throughout the inspection, in particular the pressure on the number of beds. Staff reported that due to this pressure, some patients were discharged too soon and later had to be readmitted to the CCUs.

## Multidisciplinary working

- Multidisciplinary team meetings took place on a weekly basis. This would include consultants, ITU trainees, the microbiologist, nursing staff, as well as other relevant healthcare professionals. We observed one of these meetings taking place. Staff discussed each patient's case, and the monitoring and investigations that were needed, and care plans were drawn up.

# Critical care

## Are critical care services caring?

Good



Staff on the CCUs were caring. We observed positive interactions between staff, patients and their families. People were kept informed about their care and treatment, and were involved in making decisions when possible.

### Compassionate care

- Throughout the inspection we saw patients and their families being treated in a kind and considerate manner by staff members.
- Patient's dignity and privacy was respected throughout, with curtains being drawn around cubicles when care and treatment was being provided. We observed active use of 'do not disturb' notices being utilised by staff appropriately when delivering care to patients.

### Patient understanding and involvement

- There were written records of family members being involved in the planning of and decisions about patients' care and treatment.
- In one record we reviewed, staff had documented the discussion they had had with a patient's family about resuscitation.
- Staff described the visiting hours of the department as "open door" and said they were flexible about when people could visit their relatives.

### Emotional support

- Staff had access to the trust's bereavement services, as well as a range of religious persons who provided emotional support to families/carers as required.

## Are critical care services responsive?

Requires improvement



There was a policy and procedure in place that informed staff how to handle complaints and concerns from people. Translation services were available to assist people who spoke limited or no English. However, the department was under considerable pressure and at times discharged patients before they were well enough, which often

resulted in them being readmitted. This led to additional pressure on the whole system at the hospital and the nursing and medical staff. This was not responsive to patient's needs. .

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

- There was a procedure in place to deal with a temporary increase in the volume of patients to be treated. Patients could be moved between the different types of units within the department according to their needs, and there was a dedicated member of the anaesthetic team who made these decisions.

### Access and flow

- During our inspection we noted that the service was experiencing very high levels of patient demand in relation to the numbers of available beds. Low staffing numbers exacerbated this problem, which had existed throughout the past year. Whilst interim measures had been taken to address this problem, there appeared to be limited plans to tackle the lack of capacity issue overall. Staff reported this as a major concern of theirs. They noted that this had resulted in patients being discharged at night and also being discharged before it was medically safe to do so, resulting in the patients being readmitted within 24 hours.
- **The lack of reliable data collected by the service meant that it was not possible to judge the scale of the problem, but staff described it as being "very serious".**

### Meeting people's individual needs

- The service had access to translators if needed, and these were well advertised on the wards. However, it was noted that on the intensive treatment unit the dual phones could not be brought to patients' bedsides.
- Following their discharge, all patients who had stayed in the CCUs for three days or more were invited to attend up to three follow-up outpatient appointments, in order to check on their progress.

### Learning from complaints and concerns

- When complaints were received, they were logged on to a specific computer system by administration staff, who also recorded any actions taken and escalated the issues if necessary. However, it was noted that no other staff members other than the administration staff had access to the database.

# Critical care

## Are critical care services well-led?

Inadequate



Critical care services were not well-led. There had been no clinical lead for the preceding year. Whilst concerns about the department's performance and safety were widely acknowledged within the staff base, but there had been no significant action taken to address the concerns. Staff were over-worked and under-resourced to be able to make any changes. It was not considered that the service would be able to develop into a service that provided safe, high quality care without a significant investment from dedicated leadership. Until this occurred, patients would continue to be placed at an unreasonable level of risk of harm.

### Vision and strategy for this service

- There was no overall strategy or vision in place for critical care services. It was noted that there had been no clinical lead for the past year, but staff reported that one had been appointed in the week prior to this inspection.

### Governance, risk management and quality measurement

- There were systems in place for governance, risk management and quality measurement within the department. There were specific data items that needed to be collected by staff relating to nursing and medical care, as well as other measurements, which had direct relation to the quality and safety of the care and treatment being provided. However, large amounts of this data were not collected or reviewed on a systematic basis. No systematic feedback was provided to staff. There was no facility for this information to be

benchmarked on a national basis. In addition, due to the sporadic collection rates, it could not be benchmarked against the local hospitals who used the same system as the trust. This posed very significant risks that poor care, trends of worsening care and risks to the patient safety could be missed and not acted upon.

### Leadership of service

- Nursing staff within the critical care services described a positive environment to work in (though a very pressurised one) and said that they felt well supported.
- Medical staff described working in a leadership vacuum, and said that they had serious concerns about the on-going safety of the department. The lack of vision, strategy and governance within the department were indicative of this.

### Culture within the service

- The main feedback from staff was that there was no leadership. Staff were under immense pressure (in particular medical staff) and stated that they were 'fire-fighting' with no capacity to improve.

### Public and staff engagement

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

### Innovation, improvement and sustainability

- Staff reported that due to the pressure that the department was under, there was very little time for them to reflect on practice, and there was no opportunity to undertake research.

# Maternity and family planning

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

## Information about the service

North West London Hospitals NHS Trust offers the full range of maternity and family planning services. In 2013/14 the trust delivered 4,900 babies. Almost all deliveries within the trust take place at Northwick Park Hospital. Antenatal clinics are held at Northwick Park Hospital, Central Middlesex Hospital and local children's centres. There are a number of dedicated hospital clinics for women with diabetes, blood disorders, HIV, teenagers and women with multiple pregnancies. There is an African well-woman clinic one day a week, and also clinics for people with mental health needs.

Northwick Park Hospital has a midwife-led birthing unit, which is designed for women assessed as having a 'low risk' pregnancy. It has six birthing rooms, two of which are fitted with birthing pools. The main delivery suite has 11 delivery rooms, four high dependency beds, four recovery beds, one triage assessment room, four observation trolleys and two dedicated obstetric operating theatres. There is a community midwifery service and a home birth service. Only 0.2% of births are home births.

We spoke with nine women and their partners, and 40 staff members including domestic staff, care assistants, midwives, nurses, doctors, consultants and senior managers. We observed care and treatment, and looked at eight care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

## Summary of findings

The maternity service has improved standards over the past 10 years but still has some improvements required. The unit was not meeting some of its performance targets. Although risks to the service had been identified and were being monitored, there was a lack of pace and joined up action between obstetricians and midwives that that would result in minimising risks to women using the service.

We saw that laudable attempts were being made to introduce changes that would deploy the midwife workforce more flexibly, but further effort was needed to win staff support and embed these changes for the benefit of women and their babies. The maternity service did not respond to complaints in a timely manner, nor did it actively seek women's feedback on the maternity pathway. We found evidence and women corroborated that the service they received in the unit in the most part fell below their expectations. Significant engagement with women and their families is required to ensure that the caring element of this service improves.

# Maternity and family planning

## Are maternity and family planning services safe?

Requires improvement



Historically, there had been safety issues in maternity services at Northwick Park Hospital. However, the maternity service now had a better track record on safety, based on the data on the maternity dashboard and the intelligent monitoring report carried out before our inspection. Midwives considered the service to be safe.

A number of incidents had occurred. Although systems were in place for reporting and reviewing these, the process was too slow to make a strong impact and needed to change. Medical staffing levels were sufficient. There were also sufficient midwives, but they were not deployed to best effect at all times. For example, the number of women with one-to-one support in labour was lower than would be expected given the number of midwives employed (on average only 92% of women had one-to-one support in the previous year).

### Incidents

- There had been four maternal deaths in the last two years, and four infants died unexpectedly during 2014. One mother died after her discharge.
- There was one 'never event' in 2013/14; a retained swab in a patient. ('Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.)
- In 2013 there were six admissions to intensive care at Northwick Park Hospital and a seventh patient was transferred to intensive care at a tertiary centre.
- The unit closed four times in 2013/14, once because of smoke in the unit and at other times because of capacity issues.
- The labour ward and deliveries accounted for 26.2% of serious incidents in the trust.

### Safety thermometer

- There was no specific safety thermometer for maternity services.
- There was a maternity dashboard in place which highlighted performance against safety-related targets on a monthly basis. This included indicators such as staffing levels, admissions to the neonatal unit, still

births and admissions of mothers to intensive care. The dashboard was discussed at monthly divisional risk meetings, and performance concerns were investigated. However, many areas remained 'red-rated', the highest level of concern, month on month.

- The previous month's delivery statistics were widely displayed in clinics. For April 2014, 96.67% of women had one-to-one attendance from a midwife, 58.7% of deliveries were normal births, 25% of women had caesarean sections and 16% had other interventions during delivery.
- The trust had achieved the clinical negligence scheme for trusts (CNST) risk assessment as level 1 in November 2012. (This is the level achieved by most trusts.)
- The trust appeared to assess the risk of mothers through using the Birthrate Plus workforce planning tool. However this tool looks at dependency rather than risk. True risk should be assessed from mother's risk factors at booking.

### Cleanliness, infection control and hygiene

- We observed the clinical environments of the antenatal and postnatal wards, and of the birthing unit, to be clean and tidy. Hand washing facilities, alcohol gel and personal protective equipment were available and used by staff.
- We noted that cleaning schedules were not displayed, and domestic staff did not carry checklists of the cleaning to be done that day or week.
- In some clinics, notably the sexual health clinic and the antenatal clinic, the accommodation was 'shabby' and there was insufficient seating. A domestic assistant also mentioned the desirability for more regular deep cleaning to the clinical areas.
- Between January 2013 and March 2013, more incidents of puerperal sepsis had been reported than were expected. The trust was asked by the CQC to investigate and it was found that some patient notes had been incorrectly coded, which had led to misreporting. Wound infection rates had reduced, but remained slightly above the national average.
- The service had twice the national rate of early onset Group B streptococcal septicaemia of new-borns, an infection that makes babies very sick. There had been 17 instances of this infection in the six months ending March 2014. The hospital had noted that there was a

# Maternity and family planning

high incidence of the bacterium in the local population, although it did not usually cause infection in older people. Appropriate women were now being screened for this infection.

- There had been no MRSA or C. difficile infections in the maternity services.

## Environment and equipment

- Used needles and other sharp items were left on the lid of the sharps bin in the operating theatre. This presented a potential infection risk to staff.
- There was no maintenance log for the gas analysers, which was a potential risk to patient safety.
- Staff were not all 'bare below the elbows' for the theatre briefing, in contravention of the trust's policy. This posed an infection risk to staff and patients.
- There was sufficient equipment in each area visited to ensure that patient safety was maintained. For example, there was a resuscitaire in each of the seven delivery rooms on the delivery suite, as well as two in the obstetric theatres, plus a spare.
- Staff told us that they had a sufficient number of CTG (cardiotocography) monitors, which are used to monitor the foetal heartbeat during labour.
- Resuscitation trolleys were checked daily and weekly by appropriate staff. Equipment and drugs were reordered as necessary.
- Staff told us that there were not enough computers, which limited staff productivity. They said that they had been told that this was being addressed.
- Entry into the maternity service was not secure at night. Several staff members mentioned that a homeless person sometimes came and slept in the waiting area of the antenatal clinic. However ward areas were accessed by entry phone and/or swipe cards. This was secure. Babies were tagged appropriately.
- Staff were aware of emergency procedures, and practice drills were undertaken to test staff reactions. The most recent scenario was the practice drill of the abduction of a new born baby.

## Medicines

- There were appropriate arrangements in place for the safe storage of medications in clinical areas.
- Drug fridge temperatures were checked daily and recorded. Controlled drug checks were completed appropriately.

## Records

- Comprehensive antenatal assessments were carried out when mothers registered with the hospital. Records incorporated any health or social risks to the mother or unborn child, on which the plan of care was based. Where appropriate, the booking assessment triggered a referral to a relevant service. For example, if a woman had a cardiac condition they may be referred to a consultant anaesthetist to determine what pain relief could be provided during labour.
- All women were given a 'red book', also known as the Child Health Record, which provided information on the health of their baby and the immunisations they would be expected to have.
- The hospital was part of the programme to give all babies an NHS number as part of the statutory birth notification process. However, this was not 'owned' by the consultant body, which was a barrier to full implementation.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Expectant mothers gave their consent for surgery and for instrumental procedures to be carried out. However, an audit in 2013 noted that consent for instrumental intervention was poorly documented. We did not see a recent audit.

## Safeguarding

- There were systems in place to identify and protect vulnerable people from abuse. Staff received safeguarding training in line with the trust's mandatory training.
- The trust policy was that all doctors, midwives and healthcare assistants working in the maternity department received level 3 child protection training. Student midwives attendance of training in safeguarding was low; only 16% had attended level 2 or 3 child protection training.
- Staff we spoke with were able to describe the process for reporting any concerns to social services and to identify the midwife team responsible for safeguarding.

## Mandatory training

- On average, 58% of staff were up to date with mandatory training in the women's directorate. Staff in antenatal clinics and the gynaecology department had the lowest completion rate of mandatory training.

# Maternity and family planning

## Assessing and responding to patient risk

- MEOWS (Modified Early Obstetric Warning Score) charts were used to record physiological observations in pregnancy, and to spot women whose condition may be deteriorating.
- The SBAR mechanism (Situation, Background, Assessment, Recommendation) was used by staff to communicate critical information in emergencies.
- Handovers between midwives and obstetricians took place at different times. Anaesthetists often missed part of the doctors' handover because they were busy clinically, but we saw effective exchange of ideas between anaesthetists and obstetricians. The absence of midwives from the doctors' handover meant that midwives were excluded from doctors' discussions of management plans for difficult cases.
- Consultant to consultant handover on labour ward took place when there had been a consultant resident overnight (4 out of 7 nights).
- Consultant ward rounds took place daily.
- In the operating theatre, the team briefing we observed was ineffective, because the theatre list was not available to all staff. We were told that the list order often changed at the last minute. The anaesthetist was not present for the briefing. During 'time out', the names of staff were not written on the board, and we noted that the information was spoken inaudibly. The senior house officer for obstetrics was not present and there was little focus on safety in the briefing; for example, on antibiotics or allergies.

## Midwifery staffing

- The midwifery establishment was 192 WTE, which gave a theoretical birth to midwife ratio of 1:24 compared to a national recommendation of 1:28. The recommended birth rate plus ratio was 1:25. (Birth-rate plus enables trusts to calculate staffing based on their specific activity, case mix, demographics and skill mix.)
- Levels of sickness absence among the midwifery team were high, at 5.7%. There were plans to manage sickness absence more tightly, with stricter return to work interviews. The service was also trying to tighten annual leave policy to enable better planning, but these measures were not yet in place.
- The only vacancy within the new midwifery structure was for the consultant midwife for normality.

- The maternity department used both bank and agency staff, especially at weekends. They aimed to reduce this, to 20 WTE a month from bank, and 5 WTE from the agency.
- Antenatal clinics displayed the expected and actual numbers of staff on duty.

## Medical staffing

- There was 108 hours consultant presence in place, which met the standard set by the Royal College of Obstetricians and Gynaecologists (RCOG), although this level was not compliant with the Department of Health recommendations, "Towards Safer Childbirth". This was on the maternity risk register.
- There was appropriate cover from junior and middle grade doctors during the day. There was a resident on-call consultant obstetrician for four nights a week; the other three nights were covered by off-site consultant obstetricians.
- There was concern that following a critical General Medical Council report, the number of trainee doctors would be reduced. This would have a negative effect on medical cover in future.

## Major incident awareness and training

- Midwives and healthcare assistants did regular obstetric skills and drills, but not all midwives were believed to be equally competent in all areas. There were plans to rotate midwives through different posts in order to up-skill the workforce.
- There were major incident plans in place, and simulations were run periodically.

## Are maternity and family planning services effective?

Requires improvement 

Care was based on nationally-recommended guidelines and standards. Patient outcomes had improved in some areas over time, but there was little change in other areas. The proportion of 'normal' births remained lower than the national average. Actions had been planned to reduce the number of caesarean sections and other birth interventions, but there was, so far, little evidence of impact.

# Maternity and family planning

Maternity care involved multidisciplinary, community and other teams within the trust, as well as external organisations, such as GPs and social services. There was sufficient equipment to provide effective care, and staff were trained on how to use them. Mandatory training completion rates and staff appraisal rates were lower than in other trusts, and not all midwives were keeping their clinical skills and knowledge up to date.

## Evidence-based care and treatment

- Patient's needs were assessed, and care was generally delivered in line with best practice clinical guidelines, including those produced by NICE and the RCOG. These were applied to patients based on their clinical need, to ensure safe and effective care.
- The trust had a guidelines group that reviewed guidelines. However, not all guidelines were up to date. For example, the AIDS protocol, (in the sexual health clinic), was out of date and should have been reviewed in 2011.
- All clinical guidelines and protocols were available to staff through the trust's intranet.
- Although the trust had achieved a successful audit from the London Quality Assurance Reference Centre for cervical cancer, we noted that the evidence-based guidance on 'see and treat', the precursors of cervical cancer screening, had not been adopted as standard.
- Audit practice was variable. Of the audits logged on the trust database in the previous year by the directorate, only 30% had been completed, which meant that opportunities were being lost to monitor practice against national and local standards.

## Pain relief

- Pain relief was available, and most women we spoke with reported that pain control was not a problem.

## Nutrition and hydration

- Some mothers on the postnatal ward reported that the light lunchtime menu was inadequate for breastfeeding mothers.
- Staff supported new mothers with breastfeeding.

## Patient outcomes

- 73.3% of women booked with the hospital before their 12th week of pregnancy, compared to a national target of 90%.
- The hospital had been an outlier for puerperal sepsis (May 2013) and for emergency caesarean section (July

2012). Puerperal infections were above the national average, however an audit had identified that some of this was due to miscoding and a repeat audit had shown that it was no longer an outlier.

- There had been 43 in-transit births and six unplanned home births, in the last 10 months to February 2014.
- The median length of stay in the hospital was two days.
- 87.5% of women were breastfeeding when they left hospital.
- Perinatal mortality was higher than the England average.
- The trust had higher emergency caesarean section, and lower forceps cephalic delivery and ventouse delivery rates compared with nationally. The trust's normal delivery rate, 56.8%, was lower than the national rate. Elective caesareans were at a similar level to the national level.
- Unexpected admission to NICU (neonatal intensive care unit) was the second highest origin of incidents, with 15.9%.
- There had been seven maternal unplanned admissions to ITU in the 10 months to February 2014.
- Maternal readmission rates were 2.48%. This was higher than the England average.

## Competent staff

- The appraisal rates for staff in maternity and gynaecology were low; around 30%. The highest rates were for specialist midwives at 57.9%.
- All midwives had a named supervisor. The supervisor of midwives ratio was 1:13, which was generous. The norm was 1:15.

## Multidisciplinary working

- Care and treatment was delivered by multidisciplinary teams, ensuring that people were cared for by the most appropriate person at the right time. There were specialist midwife roles for bereavement, breastfeeding and safeguarding, who acted as a source of support for staff and women.
- Staff shared information with the trust's integrated community services. Referrals were made to social services, health visitors or specialist hospitals, where there were concerns about an individual woman.
- The maternity services liaison committee (MSLC) had a Facebook page and advertised regular maternity debrief

# Maternity and family planning

sessions, facilitated by a supervisor of midwives. It was reported that this had led to a 40% reduction in complaints against the service, although we did not see evidence of this.

- A senior member of staff mentioned that the Brent and Harrow Clinical Commissioning Groups were not engaged with maternity services, despite commissioning for them.
- We saw evidence of good teamwork amongst staff on the wards.
- Where women's care was shared between the trust and GPs, all test results were sent to the women via the GP.
- There was transitional care of babies from the special care baby unit in the postnatal unit. Of note was the opportunity for terminally ill mothers to remain with their babies.
- There was access to specialist medical support at tertiary centres, such as Queen Charlotte's Hospital in Hammersmith.

## Seven-day services

- Clinics were provided Monday to Friday, although gynaecological scans were offered on Saturdays and evenings.
- Some consultants worked one weekend in four whilst some consultants did not participate in the on call rota.

## Are maternity and family planning services caring?

Inadequate



Based on what other women told us, observations during our visit, and the results from surveys, it was clear that the standard of care was inadequate in a large number of cases. Whilst we did see and hear about good care evidence provided and women spoken to did not receive good care. Of three women we spoke with on the postnatal ward, only one woman's experience met best practice standards. We also received some negative feedback about the attitudes of some staff who had not spoken to colleagues in a professional way.

In the crowded antenatal clinics, we observed that not all discussions between women and clinical staff were private. Elsewhere in the maternity service, we saw records containing personal information left where others could see them.

Sensitive emotional support was offered to women who had abnormal scans or had been bereaved. There was a specialist bereavement midwife.

## Compassionate care

- Staff appeared to be unaware of the potential value of patient input into service improvement.
- According to the 2013 CQC Survey of Women's Experiences of Maternity Services, women's experiences of labour and of the attitudes of staff were worse than in other trusts.
- We were told that the behaviour and attitudes of some midwives (perhaps 10%) towards women fell below expectations. One midwife told us that new staff just got used to some behaviours and attitudes, and would not challenge them.
- Staff mainly treated patients with dignity and respect. We observed staff interacting with women in a kind manner. Staff knocked on doors or announced their presence before entering a curtained area. However, comfort checks on the postnatal ward were not regular, with the risk that some people were left without pain relief when it was needed.
- We found a handover sheet containing confidential personal information left out inappropriately. A midwife disposed of these correctly when we pointed it out and recorded our finding as an incident.
- The response rates to the Friends and Family Test were low. Community midwifery was rated higher than hospital experiences. A number of initiatives had been put in place to increase user satisfaction, including 'customer care' and 'compassion in practice'.
- The CQC survey 'women's experiences of childbirth 2013' showed the trust as performing worse in 50% of the responses, with no improvement since the 2010 survey. An action plan had been developed, but had not made an impact at the time of our inspection.

## Patient understanding and involvement

- Women we spoke with were positive about the time and information they got from their community midwife.
- We saw from the notes of some women who did not speak English that family members had been used as interpreters, which was non-compliant with best practice recommendations set out in CMACE (Centre for Maternal and Child Enquiries) 2011.
- Women said that their conversations with clinical staff were not always private.

# Maternity and family planning

- Most women did not have a named midwife. Several women we spoke with had not had an explanation of the antenatal care pathway and what to expect at each appointment, which contravened NICE guidelines.
- A woman referred for the antenatal mental health pathway at an earlier appointment had not been contacted about that referral, so had come to her next planned appointment at the regular clinic.
- Of three women we spoke to on the postnatal ward, the experience of only one met best practice standards, such that staff had introduced themselves, treated them well, stayed with them unless they wished to be alone, explained what was happening at each stage, and afterwards helped establish breastfeeding.
- A second woman, who had not had a named midwife, had three different midwives during established labour.
- A third woman in pain following a caesarean section was in a room with a bell that did not work. She had to telephone outside the hospital for help. This incident represented a system failure, a failure of care and a failure of escalation.

## Emotional support

- There were systems in place to provide emotional and practical support for women and their partners. This included counselling and the opportunity to talk with a bereavement midwife. Memory boxes with footprints, locks of hair and baby photos were available if a bereaved parent wanted one. An appointment for psychotherapy was offered to bereaved parents if they wanted one.
- Women who had undergone a termination of pregnancy for medical reasons were also supported by the bereavement team. They could choose to be cared for on the delivery suite or the gynaecology ward.

## Are maternity and family planning services responsive?

Requires improvement



There was a good flow through the service, and women did not have difficulty accessing the service when they needed to. Women were assessed to ensure that their needs were met. The maternity service was responsive to the diverse language needs of women who used the service, and interpreters were arranged where possible.

However, not all women had been given a clear explanation of what the service offered. Also, the majority of women did not receive continuity of care. Although we were told by many midwives that women were at the centre of care, people we spoke with, and survey responses showed, that this was not women's perception of the service.

There were specialist clinics to meet the different needs of women, including mental health, safeguarding, teenage pregnancy and diabetes.

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

- The trust worked with commissioners of services, local authorities, GPs, relevant groups and people who used the service, to understand and meet the needs of the local population.
- There was a monthly meeting with GPs about shared care. 25% of patients see GPs for appointments.
- Staff demonstrated an understanding of the demographic profile of women accessing the service. They were able to describe different vulnerable groups and how they planned services to meet their needs. An example of this was the way in which community midwives carried a portfolio of approximately 100 women and made 10 visits a day. Some midwives felt it was difficult to give sufficient support to women who did not speak English under the '10 visit rule'.
- Interpreters were arranged if required, when people booked appointments, but we observed family members undertaking this role.

## Access and flow

- There was a good flow of women through the maternity pathway and we found no evidence of delayed discharges. However, there had been recent instances of too many women waiting to be triaged in the delivery suite and the service was addressing this.
- Bed occupancy of 68.7% was higher than the England average of 58.6%. Occupancy rates above 58.6% can start to affect the quality of care given to patients. This is relevant given the high rate of infection among mothers.
- Antenatal patients were referred to another provider if there was a risk that the number of births would exceed agreed limits.

# Maternity and family planning

- The gynaecology service had 20 breaches of the two week wait for cancer appointments, but on analysis this was mainly due to patients having other commitments, such as work or holidays.
- There was a home birth service available, which was provided by the community midwife team. Uptake of this service was low.
- Women attending the hospital did not have a named midwife, but were given a telephone number on which they could contact a midwife. This was unlikely to be a midwife they had met previously.

## Meeting people's individual needs

- 90% of women using the service were from ethnic minority groups, and a high proportion were not fluent in English. Some written information was available in other languages. A contracted provider was used to provide translation services. Interpreters were arranged for women when they booked their appointment, but in practice this did not always happen.
- If the antenatal screening was abnormal, women were referred to the foetal medicine consultant and received written information on their options. Depending on the gestation period, a mother agreeing to a termination of pregnancy will have this carried out on either the gynaecology ward or the delivery suite. Late terminations after 21 weeks took place at a tertiary hospital. Women, who declined to have medical terminations, had a multidisciplinary care plan produced with appropriate specialists.
- Women and their babies were only discharged when they were well enough, and had the right support in place. Before women were discharged, staff checked that they knew when their community midwife would be visiting them. They were also given information on how to contact the service if they had any concerns.
- The waiting area in the antenatal clinic was cramped. Waiting times of an hour and a half were observed on our visit, and women told us that this was not unusual.

## Learning from complaints and concerns

- There was little information in the antenatal clinic about how women and their partners could feedback on the service they had received, or how they could make a complaint.

- The number of complaints had reduced since 2012/13, but only 25% were responded to within the target time. Only 50% of those with an extended deadline for reply were dealt with in that time. We were told that there were delaying factors, included getting staff statements.
- The trust kept a database of complaints and gave feedback to staff. However, we had the impression that staff did not value the potential for learning that complaints could offer.
- The service actively engaged with women and encouraged them to share their experiences. Most women were offered a debrief session following their discharge, to discuss their birthing experience, to give them an opportunity to seek clarification, or to understand why certain things happened. This service was not just used by people who wished to make a complaint.

## Are maternity and family planning services well-led?

Requires improvement

Clinical leadership in the department was poor. Obstetricians and midwives seemed to operate separately, without a shared vision on how best to provide high quality care to women. The maternity consultation paper, while grounded in best practice had been developed without involvement of obstetrician and midwifery staff.

New leadership in the midwifery service was proposing changes that would enable the services to have more consistent skills and greater flexibility to offer high quality woman-centred care. It was evident that building support for the changes would take time as new flexible working patterns and role changes were unpopular with some staff.

There was a clear governance structure for the service which ensured that risks were identified and performance was monitored and reported upwards to senior managers within the trust. However, the fact that many of the actions set out in plans were not sustained in practice was a concern.

Staff told us that the service did not have effective relationships with the external local Clinical Commissioning Groups.

# Maternity and family planning

## Vision and strategy for this service

- There was no shared vision for the maternity service.
- A 'maternity consultation paper' had been issued in January 2014, with proposals for improving the quality of care and the cost effectiveness of the service, through using midwives more flexibly. We were told some staff were resistant to the proposals to alter working patterns, and some senior midwives in particular, felt strongly that they should have been more involved in formulating the proposals.
- The consultation had ended in late February 2014, but staff had not had any further communication from management. Making a reality of the changes would need the support of trust managers and all maternity staff. The implementation date of the changes was originally 1 April 2014, but that timetable had already slipped.
- There was a strategy in place to encourage normal births, but midwives told us that "there was a long way to go" to achieve this.

## Governance, risk management and quality measurement

- Maternity was part of women's services, which reported to the divisional general manager, who was also responsible for children's services. The governance structure ensured that there was reporting from the ward to board. Divisional governance was monitored by the trust's patient safety and quality committee.
- Quality and safety of care was managed using monthly performance dashboards.
- There was a maternity risk manager, whose role included following up incidents and monitoring any identified risks. There were 4,867 incidents open on the system, which was unacceptably high. A common issue running through incidents was communication. The introduction of the SBAR mechanism (Situation, Background, Assessment, Recommendation) was expected to show improvements over time.
- Senior obstetricians did not own take ownership of obstetric risks and there were evident tensions between midwives and obstetricians over risk management.
- A sample of incidents had been reviewed by an external person. Some incidents had shown good practice by staff, and where this happened, staff had been commended.

- There were systems in place to ensure that the trust met its legal requirements under the Abortion Act 1967. Abortions were only carried out for medical reasons, such as foetal abnormality, and had to be agreed to by two doctors.
- Senior staff were aware of the risks that may impact on the safety or effectiveness on the service, and these were logged on the trust's risk register and monitored at monthly risk meetings. Trends were also reviewed. However, risk information was not widely shared with relevant members of staff.

## Leadership of service

- There appeared to be both poor working relationships between senior managers and poor working in multi-disciplinary teams.
- Staff told us that the hospital's senior management and board were not very visible. We were told that the number of senior staff in interim or acting posts created a sense of instability.
- Midwives reported that they were well supported by the supervisors of midwives, and all had an annual review. The supervisors also monitored their performance on an on-going basis, and midwives said all the supervisors of midwives were approachable. The trust had a supervisor to midwife ratio of 1:12, which was above the national standard.
- There was a lack of engagement from obstetricians in managing the service or driving change, such as to significantly reduce lower section caesarean section rates.

## Culture within the service

- We did not detect a strong collective will for midwives and obstetricians to drive improvements.
- Midwives described the culture in the delivery suite as very dependent on the co-ordinator of the shift. There were different management styles, and some co-ordinators were perceived as less supportive than others. At weekends there were a lot of bank and agency staff, and teamwork was sometimes less effective as a result.
- Some staff mentioned tensions and differences of approach between some obstetricians and some midwives.
- Some midwives told us of their reluctance to speak out if they had a concern, and a fear of being 'judged'. However, other midwives sought out CQC inspectors to give their own positive views of the service.

# Maternity and family planning

- We were told that junior consultants were reluctant to challenge the clinical director.
- There was a high turnover of consultant staff within the department and we did not see evidence of exit interviews with these staff.

## Public and staff engagement

- The chief executive kept staff informed of developments through the intranet, which staff said was helpful.
- The director of midwives held an open forum weekly between 8am and 10am in an effort to improve communication.
- The maternity services liaison committee (MSLC) had a Facebook page, and advertised regular maternity debrief sessions, facilitated by a supervisor of midwives. This had led to a 40% reduction in complaints from women.

- Senior staff mentioned that the Brent and Harrow Clinical Commissioning Groups were not engaged with the maternity services, despite commissioning them.

## Innovation, improvement and sustainability

- The trust had produced an attractive credit card-sized prompt for staff about the strategy for compassion, quality and safety.
- The consultant to consultant handover on the labour ward was high quality.
- The feedback from junior doctors was that they received good supervision on the labour ward day and night.

# Services for children and young people

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

## Information about the service

Northwick Park Hospital has one 24 bedded children's ward with medical and surgical beds, known as Jack's Place. Up to three of these beds can accommodate high dependency patients. The local neonatal unit (previously known as Level 2) is based within the maternity block and has eight ITU/HDU cots and 20 special care baby unit cots. The unit cares for babies over 27 weeks gestation. The unit is part of the North West London Neonatal Network.

A paediatric day care unit (Chaucer) provides facilities for children requiring chemotherapy, diagnostic tests, consultations and follow-up appointments. The unit also provides day surgery. Northwick Park Hospital is a Paediatric Oncology Shared Care Unit (Level 1).

We spoke with five patients and three relatives, as well as 21 staff members including consultants, junior doctors, nurses, domestic and support staff. We observed care and looked at care records of six of post-operative or acute patients, and we reviewed other documentation, including performance information provided by the trust. We received comments from our listening event, and from people who contacted us to tell us about their experiences.

## Summary of findings

Services for children and young people at Northwick Park Hospital require improvement. Children received effective care from staff trained to work with children. Staff engaged well with children of different ages. The facilities were generally good, particularly in the day care/children's outpatient area. Staffing and skill mix on the ward, the neonatal unit and the day care/outpatient service were sufficient.

However, there was insufficient space for storage of equipment on the children's ward, and some areas were cluttered.

Parents had confidence in the care that their children received, and spoke positively about staff's compassion and communication. We observed staff showing care and responsiveness to individual children. However, we found some areas where safety needed to be strengthened, such as ensuring that clinical equipment was not accessible to children on the inpatient ward, and that medical equipment was serviced annually.

There were arrangements to meet the diverse language needs of the population served by the hospital. However, there was a lack of joined-up working across the medical team, and between doctors and nurses. We also found that the service itself was distant from the trust board. There were no processes to obtain the views of the service from families and friends, although we were told that some ideas were being considered.

# Services for children and young people

## Are services for children and young people safe?

Requires improvement



Children services require improvement as there were a number of concerns about safe storage and maintenance of equipment. This related to medical equipment not being on the trusts asset register and potentially missing vital service dates. Wards were cluttered making it unsafe for patients, family as well as staff. We saw an example of this when a blood specimen was left on an open shelf where children could have reached it. There was evidence of safe care and readiness to learn from incidents, and to improve practice and procedures. Safeguarding practice was robust; however, many staff had not completed their mandatory training. Patient medical records were legible and up to date, including regular observations and risk assessments.

The service for children and young people had a low number of incidents and complaints, but when these occurred, they provided learning opportunities for staff. However numbers of people receiving mandatory training were poor and some staff did not have the appropriate level of safeguarding training.

### Incidents

- The children's directorate had not reported any serious incidents or 'never events' in the last 12 months.
- Staff told us that incident reporting on the electronic system was improving, although there was a backlog of about 24 incidents for which, at the time of our visit, an investigation had not been started. Examples of incidents that had occurred included drug errors and the attempted abduction of a baby.
- There had been four unexpected neonatal deaths in the past year.

### Cleanliness, infection control and hygiene

- Hand washing facilities were adequate, and hand gel and personal protective equipment (gloves, aprons, etc.) were available, and we saw them being used appropriately.
- There had been no cases of MRSA, C. difficile, or norovirus on the children's ward in the past year.
- Children needing isolation were cared for in single rooms, and we saw appropriate infection protocols being observed by staff.

## Environment and equipment

### Jack's Place

- Jack's Place was secure from unauthorised persons, and access was restricted by entry phone and/or swipe cards only. However, the design of the ward meant that many areas were not observable from the nurses' station or the reception desk, which posed a safety risk when children were playing in the ward.
- We observed a number of safety issues: some electrical equipment did not have PAT testing dates, and trust records showed that on the children's ward, 24% of equipment had passed their due date for servicing.
- Not all equipment in the ward was on the trust's asset register, which was why service dates had been overlooked. Staff on the ward were unclear as to whose responsibility it was to report overdue service times.
- The ward appeared clean, but it was cluttered, which meant that thorough cleaning could not be achieved. Cleanliness audits were carried out by the contracted cleaning agency, not by nursing staff.
- For equipment that nurses cleaned, we were told that the healthcare assistant kept a cleaning diary, but this could not be found. No 'clinically clean' tags were in use on the ward, and staff seemed uncertain when cleaning took place.
- The treatment room and store room doors on the ward were left open, potentially allowing access to children.
- On the day of our visit there were blood samples on a shelf in the open area of Jack's Place awaiting collection, because the pneumatic tube system to take samples to the laboratory was out of order. Children could have had access to these.
- Toys appeared clean and in good condition, but there was no cleaning schedule seen for these.
- The single rooms in the corridor section felt isolated from the main ward.

### Neonatal unit

- The unit was secure from unauthorised persons, and access was restricted by entry phone and/or swipe cards only.
- The nursery areas were all clean.
- The unit was equipped with essential items to support the care and treatment of infants.
- We noted that a fridge in the neonatal unit was iced up, and there were gaps in the temperature recording. The temperature readings on several days exceeded the

# Services for children and young people

recommended range of 2-8 degrees Celsius, but no action appeared to have been taken. Furthermore, the fridge contained an out of date blood sample dated 2012.

## Chaucer Unit

- This unit appeared clean and uncluttered.
- Some cleaned items were marked with white laminate labels on which the date was written. This system appeared unique to the day care unit. It was not used in the adjacent children's ward.

## Medicines

- There were appropriate arrangements for the safe storage of medicines. Evidence from children's medical records showed that medicines were given appropriately.
- The correct procedures were used for checking and recording the use of controlled drugs.
- Following a serious incident, there was increased attention paid to identifying allergies before prescribing drugs. However, we noted that on 20 May 2014, four out of 17 patients had not had the allergy question answered.

## Records

- We were told that children were risk assessed on admission, but this was not always recorded in their notes.
- Care plans were updated regularly, although we noted that pain scores were not always recorded.
- Observation charts were fully completed.
- Admission booking, notes collation, discharge and appointments were all carried out by a ward clerk. However, as there was no ward clerk in place at weekends or on bank holidays, not all information was fully recorded at these times.
- We were told that there were delays in discharge letters for children being sent to their GPs.

## Consent

- Parental consent was recorded on all the children's notes we reviewed.
- Older children told us that they were involved in discussions about their treatment, and gave their own consent, along with their parent. This was documented.

## Safeguarding

- Staff we spoke with could describe the referral process for alleged or suspected child abuse, and knew the names of safeguarding leads. A paediatrician was the named doctor for safeguarding.
- Sufficient staff were trained to level 3 in child protection in Jacks Place.
- We saw evidence that the computer system flagged up children known to social services. A sticker was used on paper notes prompting consideration of potential safeguarding issues, such as unexplained delay in seeking treatment.
- Child protection issues were flagged on handover sheets.
- The named doctor for safeguarding ran peer review meetings on alternate weeks to review child protection cases.
- Staff on the wards and outpatients told us that they had up-to-date training in paediatric basic life support (PBLs) and in safeguarding.
- Only 26% of staff in the neonatal unit had level 3 safeguarding for children.

## Mandatory training

- Completion of mandatory training averaged 56% across children's services. It was particularly low in the neonatal unit.
- Jack's Place averaged 83% for completion of mandatory training, but only 21% were up to date on infection control training. This was a concern as cleaning tasks by nurses required improvement.
- One nurse reported that they had had only one training day outside the mandatory training in three years.
- There was a paediatric resuscitation officer, and we were told that there was a good take up of training on paediatric intermediate life support and advanced life support.

## Assessing and responding to patient risk

- Risks were discussed at monthly meetings, and lessons learned were recorded in the minutes.
- Paediatric early warning scores were used to assess the state of children's health, and enabled nurses to escalate concerns if the patient's condition deteriorated. We saw completed observation charts in children's records.

# Services for children and young people

## Nursing staffing

- We were told that there had been staffing issues in the past, particularly in the day surgery unit. We also noted that the children's ward had employed a number of agency staff in the previous month.
- However, there were sufficient suitably skilled nurses on the children's wards, although agency staff were needed to achieve adequate nursing levels. Two nursing staff vacancies had just been filled.
- Unexpected staff absences were filled using paediatric-trained bank staff as far as possible. We noted that there had been 49 agency shifts in April 2014 in Jack's Place.
- Where a child needed one-to-one care, additional staff were booked.
- There were concerns about recruitment and retention of neonatal nurses. The age profile of the neonatal nurses in post meant that a high proportion of them were nearing retirement.
- If there were children needing high dependency care, the number of nursing staff was increased, so that the ratio would be one nurse to two children.

## Medical staffing

- There were sufficient suitably skilled doctors; however, there were concerns about an expected reduction in the number of trainee doctors, which would impact on staffing levels.
- Paediatric ward rounds took place daily, including weekends, and included surgical patients.
- There was appropriate cover from junior and middle grade doctors on the children's wards, during the day and at night.
- We observed effective and thorough handovers by doctors and by nurses on both the neonatal unit and Jack's Place. The handovers between doctors and between nurses took place at different times.
- The neonatal unit had four consultants, of whom two were locums. There were two part-time, short-term locums also working in the department while a consultant post was being advertised. Five consultants were needed to cover the unit safely. The consultants were supported by seven neonatal middle grade doctors and seven neonatal junior doctors.
- The neonatal team kept in daily contact with the maternity unit, to determine if there were any potential admissions.

- Day surgery was provided by surgeons, anaesthetists and nurses, who all specialised in paediatrics.

## Are services for children and young people effective?

Good



Care and treatment was evidence-based, and delivered in line with national standards. The service took part in a number of national audits for which we saw the results. Following the recent recruitment and the filling of vacancies, there was now an appropriate skill mix of staff on the ward and day care unit.

There was strong multidisciplinary working, involving community nurses and therapy staff. Junior doctors said that there were regular training sessions.

## Evidence-based care and treatment

- Children and young people's needs were assessed, and care and treatment was delivered in line with nationally-recommended guidance, such as NICE guidelines and evidence-based practice.
- The guidelines for treating childhood illnesses were found to be up to date.
- Staff knew where to find policies and local guidelines, on the intranet, and in hard copy.
- The hospital carried out local audits on various topics, including pain in children and infection screening of patients for surgery. We noted that that there had been improvements over time.
- Examples of the good practice noted in the neonatal unit included oxygen saturation measurement as part of new born baby checks, the use of probiotics, and the use of end tidal CO<sub>2</sub> in intubation.
- Transitional care was evolving, staffed by the neonatal unit, and was thought to be an effective initiative to help mothers adjust to their babies leaving the special care baby unit.

## Pain relief

- Three children told us that staff asked them about their pain, and said that they had felt better after they had been given analgesics. Not all children's notes recorded a pain score or a review post-analgesia. We were shown a paediatric pain assessment chart, but did not see this being used in the children's notes we reviewed.

# Services for children and young people

- The hospital had an acute and chronic pain team that also worked with children. We saw pain control protocols for patients with sickle cell disease.
- We did not see a pain management protocol to monitor or treat pain in neonates, but observed that staff used sucrose or breast milk to calm babies. Baby massage was also used by staff to relieve pain in neonates.

## Nutrition and hydration

- Children we spoke with were content with the hospital food.
- We noted that one child in Jack's Place had not been referred to a dietician, despite having allergies to two food groups.

## Patient outcomes

- An audit showed that about 26 children a month needed short periods of high dependency care in Jack's Place. There was a designated area for such cases.
- Postnatal neonatal readmissions were 0.12%. This was lower than the national figure.
- The service took part in national clinical audits to benchmark its performance, including the national paediatric audits on diabetes, epilepsy, asthma and pneumonia, and the neonatal audit programme (NNAP). The asthma audit showed that care at Northwick Park Hospital was comparable with care nationally, and that there was less unnecessary intervention and better discharge planning than previously.

## Competent staff

- All staff on the children's ward and neonatal unit had appropriate neonatal or paediatric training. Staff reported that training was high quality.
- Junior doctors reported very good training in paediatrics. We noted that the current programme of lectures for doctors was wide ranging, and drew on expertise from outside the hospital.
- Medical staff felt well supported by each other.

## Multidisciplinary working

- We saw evidence of regular multidisciplinary team (MDT) meetings taking place in the children's ward. Discussions involved pharmacists, physiotherapists, speech and language therapists, dieticians and clinical nurse practitioners, as appropriate. There was a weekly child protection MDT meeting.

- Every Tuesday, there were psychosocial meetings designed to prevent problems, as well as to respond to particular concerns.
- Specialist leads for child protection and bereavement provided advice and support as appropriate, and social workers were involved as necessary. There were no social workers who were based on site.
- Referrals were made to other hospitals where necessary within the London North West Newborn Network.
- Complex paediatric cases and all under 5s were referred to specialist hospitals, particularly Chelsea and Westminster, St Mary's and Great Ormond Street.
- Registered mental health nurses were always obtained from agencies if required for patients in Jack's Place.
- Child and adolescent mental health services (CAMHS) provision, provided by the local mental health NHS Trust, was unsatisfactory. Young people were only seen by CAMHS on the day of admission if a referral had been made by 11am. There was no out-of-hours cover. The result was that medically-stable children had to be supervised by agency registered mental health nurses brought in for the purpose, and this blocked a bed until they were seen by CAMHS. This was not in the best interests of the young person or the ward. Paediatricians had raised this concern with the relevant authority.

## Seven-day services

- The children's service was consultant-led, with consultants on site on weekdays and at weekends. They conducted ward rounds seven days a week. A consultant was on site on weekday evenings from 6pm to 8pm, and then on call until 8am. At weekends, a consultant was on site 8am to 2pm, and then on-call thereafter.

## Are services for children and young people caring?

Good



Parents and children said that the service was caring, and that their needs for information and support were met. We observed good interaction from medical staff and nurses with patients and their families. Clear explanations enabled families to be involved in the care of their children and in decision-making.

# Services for children and young people

We saw good evidence of practical and emotional support for families.

## Compassionate care

- Staff treated children in a kind and reassuring manner. Children told us that the nurses were friendly and helpful, and responded quickly to their call buzzers.
- Relatives felt staff generally kept them well informed.
- One parent was able to stay overnight with their child in Jack's Place.
- Lots of thank you cards showed that parents and children appreciated the service.

## Patient understanding and involvement

- All the children and young people we spoke with said that nurses offered them choices and explained what they were doing.
- Older children said that they were involved in their care plans.
- The hospital provided child-friendly information about conditions; we saw a child using a fun exercise book about living with diabetes.
- The children's units produced clear information for parents; there was general information about the ward, day surgery procedures, general anaesthesia and procedure-specific leaflets, such as adenotonsillectomy advice.
- Parents of children coming to clinics for diagnostic tests were sent written information about tests. They were also given written information about chronic conditions. Parents said that they had been given time to talk to staff about how to support their child during their illness.
- Parents and carers were kept informed if there was a delay to their child's treatment.

## Emotional support

- Families were supported by community nurses and consultants in the event of a death. When babies died, memory boxes were available that included photographs and foot and handprints. If parents did not want these immediately, the hospital kept them with the baby's notes in case they were requested for them later.
- There was also debriefing for staff following child or baby deaths.
- Parents of inpatients were able to discuss any concerns with the consultant responsible for their child.

## Are services for children and young people responsive?

Good



There were arrangements to meet the diverse language needs of the population served by the hospital, using a contracted provider and interpreters. There were leaflets for families in a variety of languages. Some appointments were made by telephone using the contracted interpreting service rather than by letter, as this improved attendance at outpatient appointments.

Discharge planning meetings took place, and involved the family, as well as community services, to ensure that the right support was available at home. There were no processes to obtain the views of the service from families and friends, although we were told that some ideas were being considered.

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

- GPs were able to refer children to urgent-access clinics, which ran three times a week.

## Access and flow

- There was a steady flow of patients to the children's ward, both day cases and inpatients, and we were told that the ward occupancy rate was around 80%.
- Admissions to the ward came under the consultant on duty that week, unless the child was already known to another consultant.
- In outpatients, waiting times were fairly short.
- Parents were given information on the discharge of their child, and an outpatient appointment referral to community nursing was made, if required.
- Parents we spoke with were involved in the plans for their child's discharge, and felt well informed about how to look after their child at home.
- The neonatal unit had a small outreach team in the community, which supported parents with caring for their baby.

## Meeting people's individual needs

- Interpreters could be arranged where children or their families required this.
- There was a lounge for adolescents in Jack's Place, so they could be separate from younger children.

# Services for children and young people

- The local authority no longer provided tuition to children whilst they were in hospital, so parents had to contact their children's schools to make tuition arrangements.
- Children who had been inpatients were sometimes asked to come back for a review on the ward, but there was no direct referral to the ward. Children had to be admitted through A&E.
- Volunteers provided professional help, through a support group for families whose babies had been in the neonatal unit.
- We heard about good practice in end of life care. There was contact with a palliative care nurse from Great Ormond Street, a quiet room for families, involvement with local child hospices and access to counselling.
- Staff told us that families will often use their own spiritual leader for emotional support, although the hospital offered Christian, Hindu, Muslim and Jewish chaplaincy services, and had contact numbers for other faith groups.

## Learning from complaints and concerns

- Information was displayed at outpatient clinics on how people could provide feedback on the service they had received, and how they could make a complaint.
- Complaints were followed up in discussions with families. We saw a recent example of this, and the incident in question was to be used in the training of staff.

## Are services for children and young people well-led?

Requires improvement 

There were developments in motion to improve care, which were focused around the merger with Ealing Hospital NHS Trust. However, it was also clear that the prospect of the merger had created uncertainties for staff, which may have affected their support for change. There was a lack of joined-up working across the medical team, and between doctors and nurses.

The children's service had its own governance arrangements. However, the service itself was distant from the board. Most staff were not able to tell us who spoke for children's services at board member level.

Children's services learned from incidents and from audits to improve care. However, the failure to engage patients and families in service improvement was a barrier to developing a service to meet patient needs as effectively as possible.

## Vision and strategy for this service

- The planned merger with Ealing Hospital NHS Trust had provided a focus for refreshing the vision for delivering children's services and for continuing to reconfigure the service.
- The high level vision was to provide safe, high quality, patient-centred, generalist services for babies, children and young people, through integrated acute and community services. Representatives from across the service had been involved in developing this vision, which was published in October 2013. However, we did not gain the impression that the consultants were fully united around this vision.
- The neonatal unit took part in the baby friendly (UNICEF) scheme to support breastfeeding and strengthen mother, baby and family relationships. It had achieved level 3.

## Governance, risk management and quality measurement

- Paediatric clinical governance meetings covered learning from serious incidents elsewhere in the trust. They also included learning from complaints, discussion of cases, feedback from incidents and reviewing audits.
- A number of local and national audits took place in order to measure quality.

## Leadership of service

- We were told that there were some tensions between medical staff, and they did not function as a leadership team for the service as a whole.
- The matron for Jack's Place also had responsibility for the outpatient clinic at Northwick Park Hospital (Chaucer).
- Consultants held weekly meetings to review the care in Jack's Place, but nurses did not always attend.
- Staff on the neonatal unit held weekly business meetings that were minuted, with actions for named individuals.
- There was an annual session for staff on major incident awareness, and a major accident plan had been drawn up two years ago.

# Services for children and young people

## **Culture within the service**

- Nurses considered the culture in the children's service to be open, and stated that there was no blame attached to reporting incidents.
- Junior doctors said that consultants were supportive and that there was a well-run teaching programme.

## **Public and staff engagement**

- The children's services did not use Friends and Family Tests, and there were no formal processes to obtain the views of families, children and young people. We were told that staff were working on ways of seeking feedback, but we did not see any documents to support this.

## **Innovation, improvement and sustainability**

- A good example of innovation was the jointly-created integrated care plan for asthma care, developed with GPs. This had been shown to reduce A&E attendance by half, and reduced admissions by one third.
- A project to recognise levels of pain in non-communicating children had been piloted with a primary special school, and further work was taking place to explore its use with secondary school pupils.
- The neonatal unit has been very effective in raising breastfeeding rates.

# End of life care

Safe	Good	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	
<b>Overall</b>	<b>Good</b>	

## Information about the service

Palliative care is provided for all the hospitals in the North West London Hospitals NHS Trust by the specialist palliative care team (SPCT) based in the Macmillan Unit at St Mark's Hospital. Specialist palliative care is advised for patients who are suffering with advanced symptomatic disease, or who are no longer suitable candidates for curative oncological intervention.

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

## Summary of findings

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

Staff hoped that the recent appointment of a non-executive director lead in end of life care would increase the department's visibility with the board. End of life care training was not mandatory within the trust, and this meant that healthcare professionals at the hospital found it difficult to attend the courses provided by the SPCT. The SPCT were researching into how to provide an integrated care pathway that involved community services such as nursing, palliative care, GPs, ambulance, hospices and care homes, to frail and older patients, and those dying through complex health issues. It is hoped that this would also decrease the number of unnecessary admissions to the hospital.

# End of life care

## Are end of life care services safe?

Good



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

The records we reviewed were found to be appropriately completed, and medicines were appropriately prescribed. Staff understood how to safeguard patients from abuse. They were aware of the Mental Capacity Act, and what to do if someone was unable to give informed consent.

### Incidents

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

### Safety monitoring

- The clinical audit marginally fell below the national average in two areas. The trust scored 57% for

multidisciplinary team (MDT) recognition that a patient was dying (nationally 59% was achieved); and 48% for medication prescribed when necessary for the five key symptoms (nationally 50% was achieved).

- The trust scored above average in all other areas of the clinical audit, which included nutrition, hydration, spiritual needs, discussions with the next of kin that the patient was dying, plan of care for the dying phase and care after death.

### Medicines

- The records we looked at showed that patients whose condition could deteriorate required medicine to alleviate their symptoms. Arrangements were in place to ensure that medicines had been prescribed in advance, so that patient's waiting time and discomfort were minimised.
- There was a medicines support team on the wards for older people. They liaised with GPs, social services and the palliative care team to ensure that people received appropriate care once they were discharged from the hospital. Patient's prescription charts showed that they had been prescribed appropriate medicines for palliative care, which included pain relief and anticipatory medicines, such as medicines for nausea and vomiting.
- The palliative care team provided patients who were returning to their home with a supply of their medication and a leaflet listing the medicines that they were taking.
- Some patients received palliative chemotherapy to support their symptoms. There was good multidisciplinary working between the chemotherapy day unit at St Mark's Hospital and the pharmacy department, to ensure that patients received their treatment without unnecessary delay.
- Electronic prescribing was in place for colorectal and lung cancer clinics. This meant that information was easily available to all departments to ensure that drug treatments were prepared by the pharmacy on time.
- There were plans to roll out electronic prescribing to other clinics, as we were told that sharing paper-based information, such as blood test results between departments, had the potential to cause delays in the preparation of drug treatment. The unit kept supplies of supportive treatments, such as anti-emetics, to avoid

# End of life care

having to send unwell patients to the pharmacy department, and there was good liaison between the unit and the palliative care and community nursing teams.

- Patients receiving chemotherapy on the wards were supported by staff from the day unit.
- We were told that some patients had experienced problems receiving their treatment in the community, because in some areas, community nurses required an authorisation from the GP to administer certain medicines.

## Records

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

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

## Safeguarding

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

## Mandatory training

- All nursing and clinical staff had completed their mandatory training.

## Assessing and responding to patient risk

- The SPCT told us that they would not expect to be asked to attend to every patient who was dying in the hospital, as many of the consultants at the hospital responded appropriately when a patient's condition was deteriorating.
- New patients and urgent cases referred to the SPCT were prioritised and discussed at weekly MDT meetings.
- The ward staff we spoke with were aware of the palliative care team and requested their support if they recognised that a patient's condition was deteriorating or if they needed reassurance that an appropriate course of action was being taken. However, the SPCT reported that some medical staff did not agree with the advice that the clinical nurse specialist (CNS) gave and would, on occasions, continue with a course of curative treatment when a patient was in the latter stages of dying.
- The SPCT checked with nursing and medical staff as to whether a patient had responded to any changes to their treatment.

# End of life care

## Nursing staffing

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

## Medical staffing

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

## Extended Team

- Oncology support and advice was available from staff running the Macmillan kiosk in the main entrance of the hospital.

## Are end of life care services effective?

Good



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

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

## Evidence-based care and treatment

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

## Pain relief

- The patients we reviewed received appropriate pain relief.

## Nutrition and hydration

- The patients we reviewed received appropriate nutrition and hydration.

## Patient outcomes

- The trust took part in the National Care of the Dying Audit for Hospitals (NCDAH). The audit is made up of an organisational assessment and a clinical audit. The trust achieved four out of the seven key performance indicators (KPI) in the organisation audit, and seven out of ten for the clinical audit.
- The SPCT had analysed the main findings of the audit and proposed a number of recommendations to improve the service provided.
- The trust opted out of the bereavement audit summary as a majority of patients' notes did not contain the next of kin details, so they were unable to obtain bereaved relatives views.
- The SPCT had good links with the community palliative care team, so that patients could receive continued support within the community.

## Competent staff

- All nursing staff had annual appraisals on their performance with their manager.
- Staff had a supervision meeting with their manager once every six months.
- The CNS and consultants were required to complete continuing professional development courses, and they attended various other courses relating to their role in end of life care.

# End of life care

- The team had increased their profile with the trust; however, this had led to an increased referral rate across the trust, from 450 in 2012 to 1,000 in 2013. Staff resources were stretched, as their workload had doubled and the staff numbers had remained the same.
- End of life training was offered by the SPCT to all staff within the trust. However, this was not currently mandatory as recommended nationally. The training included: communication training, how to have difficult conversations, identifying the signs of dying and policies on syringe drivers.
- The SPCT team told us that it was difficult to engage junior doctors and consultants in the training, and nursing staff found it hard to attend due to work pressures. 25% of staff had undertaken training.
- Porter services were provided by a private company. The bereavement officer had identified a need for the porters to be trained in dignity around bereavement and transportation of bodies. 75% of the porters had received an in-house training course. They reported that the course was very useful, and had given them confidence and pride in their work. One porter told us how their knowledge had meant that they were able to challenge a member of ward staff with regard to incorrect identification being attached to a body.
- Some of the SPCT CNS's were studying for a qualification to become a nurse prescriber. This would mean that they would be able to prescribe appropriate medicines, as well as advise on them.
- The bereavement office assisted junior doctors on how to fill out the medical certificate of death, in order to prevent the registry office rejecting them for being completed incorrectly. This meant that distress to families would be minimised.

## Multidisciplinary working

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

## Seven-day services

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

## Are end of life care services caring?

Good



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

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

## Compassionate care

- During our inspection we saw patients being treated with compassion, dignity and respect. 'Thank you' letters showed how much patients and their families valued the support, advice and care that the SPCT gave to them.
- Staff spoke passionately about how they cared and supported people.
- Normal visiting times were waived for relatives of patients who were at the end of their life.
- The SPCT told us that they encouraged ward staff to sit with patients who did not have regular visitors at the end of their life.
- If appropriate, a patient was moved to a side room to offer more privacy when they were nearing the end of their life. If this was not possible, curtains were drawn around their beds.
- Deceased patients were moved from the ward to the mortuary as soon as was practicable. We saw porters handle bodies with care and dignity while transporting them to the mortuary.

## Patient understanding and involvement

- Patients were given a named nurse on the wards.

# End of life care

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

## Emotional support

- CNS supported patients and their relatives. People were given as much time as they needed to talk about their thoughts and feelings.
- Macmillan staff were available at the hospital, and provided support to friends and relatives.
- Patients had assessments for anxiety and depression, and appropriate clinical support was offered.
- A psychotherapist was available for bereaved parents on the neonatal ward.
- Multi-faith chaplaincy was available, if required, to provide spiritual support.
- The bereavement officer supported relatives/friends after the patient's death by explaining all the legal processes, and what to expect after someone has died. They provided an information pack which included the contact details for support and counselling groups.
- Parents of miscarried babies were offered a funeral service in the hospital chapel. The bereavement officer told us that many of the parents found this support valuable, as it gave them an opportunity to share their experience with other people, and allowed them to grieve for their child. The hospital could also arrange for their babies to be cremated and for them to have the ashes.

## Are end of life care services responsive?

Good



Overall we found the end of life care service to be responsive to people's needs. It had been identified by the SPCT and the NCDAAH that some staff did not recognise the stages of dying, which meant that some patients may continue to receive curative medicines which might not be

appropriate. However, the number of patients referred by healthcare professionals to the SPCT had doubled in the last year, which meant that more staff were recognising the signs of a deteriorating patient.

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

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

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

## Access and flow

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

# End of life care

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

## Meeting people's individual needs

- The SPCT had identified that some healthcare professionals did not always recognise the early stages of dying and therefore, on occasions, continued with curative treatment when it was not appropriate.
- Interpreters were available for people who were unable to understand English.
- A multi-faith chaplaincy was available. There were full-time Church of England and Catholic priests, and part-time Muslim, Jewish and Hindu spiritual leaders available.
- The hospital did not have a bariatric trolley at the time of our inspection. However, staff had identified a way of transferring bodies too large for the usual mortuary trolley which retained the dignity of the deceased.
- We were shown a breakdown of where people wished to die against the number who actually died in their preferred place. However, this had not been fully completed since February 2013. The six months prior to that showed that the majority of people did not die in their preferred place. We were unable to ascertain the reason for this.
- The bereavement and mortuary services took into account people's religious customs and beliefs, and were flexible around people's needs. An example of this was where a family did not wish for their relative's body to be taken to the mortuary, so it was arranged for the body to lie in the chapel of rest until the funeral director arrived that day.
- We were told that a terminally ill mother could be cared for alongside her baby.
- The trust did not achieve 'providing specialist support for care in the last hours or days of a person's life'. This was because they did not provide face-to-face specialist palliative care services from 9am to 5pm, seven days a week, although there is a national recommendation that this should be provided. Nationally, 21% of trusts achieved this. However, there was access to a telephone helpline out of hours.

## Learning from complaints and concerns

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

## Facilities for relatives/carers

- Most of the adult wards did not have an adequate space where staff could talk with relatives privately, or for relatives to have some personal time away from the ward. The staff used clinic rooms on the wards when they were required to speak to people about more sensitive issues. There was a separate lounge area for this purpose on the children's ward.
- The A&E quiet room was used for relatives/friends to spend time with the deceased patient, or to discuss sensitive issues. This was not an ideal environment, as you could see ambulances regularly arriving outside the window.
- The bereavement office provided comfortable seating, and the bereavement officer had personally provided some home furnishings to make the environment feel less clinical.
- There was a bed available for a parent to use while staying with their child on the children's ward.
- There was a multi-faith chapel and prayer room.

# End of life care

## Are end of life care services well-led?

Good



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

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

### Vision and strategy for this service

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

### Governance, risk management and quality measurement

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

### Leadership of service

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

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

- The lead clinician and lead CNS were responsible for the day-to-day running of the team. They were very energetic and had a positive vision for end of life care within the trust.
- All the CNS felt supported by the management team, and shared in the department's vision to provide a caring and responsive approach for people requiring palliative care.
- The management team and staff all agreed on the challenges and pressures they faced.
- The bereavement officer was well respected by colleagues, and supported doctors, porters, the chaplaincy and mortuary staff through a very professional approach.

### Culture within the service

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

# End of life care

## Public and staff engagement

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

## Innovation, improvement and sustainability

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

# Outpatients

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

## Information about the service

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

There is a centralised outpatients area with a main reception. Individual clinics are run in this area, with their own reception desks. The clinics held here include endocrine, infectious diseases, neurology, respiratory, vascular surgery, haematology, diabetes, phlebotomy, dermatology, urology, trauma and orthopaedics, general surgery and oncology. Other outpatient services are run and managed elsewhere in the hospital by their own directorates. These include cardiology, medicine, care of the elderly, obstetrics and midwifery and paediatrics.

During our inspection we visited the main outpatient area and visited the clinics for haematology, dermatology, diabetes, orthopaedics and urology. We met with 18 staff including receptionists, nursing staff, healthcare assistants, consultants, administration staff and the manager of the outpatients department. We spoke with seven patients. We looked at the patient environment, and observed waiting areas and clinics in operation.

## Summary of findings

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

Patient notes for the individual clinics were kept in open trolleys, and we saw that on occasions, these were left unsupervised. The lack of secure storage meant that there was the possibility of confidentiality being breached.

Clinicians took sufficient time in consultations, and patients said that they felt involved in their care. The demand for some of the clinics was greater than the capacity. This meant that some clinics ran late and also had long waiting times for appointments. There were initiatives in place to consider moving some services to improve their efficiency.

# Outpatients

## Are outpatients services safe?

Requires improvement 

The patient outpatient areas were clean and well maintained. Infection control procedures were followed, and regular audits were completed. Patient notes for the individual clinics were kept in open trolleys, and we saw that on occasions, these were left unsupervised. The lack of secure storage meant that there was the possibility of confidentiality being breached. Patients were at times being seen without a full set of notes being available to the consultant in charge of the clinic.

### Incidents

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

### Cleanliness, infection control and hygiene

- The main waiting area was clean and well maintained. Patients we spoke with said that the consulting rooms were clean, and staff we spoke with told us that cleanliness standards were maintained. Staff told us that if additional cleaning was required this was quickly organised.
- Regular infection control audits were completed and the reports provided to the outpatients manager.
- The toilet facilities were regularly checked and cleaned.
- 'Bare below the elbow' policies were adhered to in the clinical areas.
- Hand hygiene gel dispensers were provided in the waiting areas, and we observed these being used by patients and staff.
- Staff completed infection control training as part of their mandatory training.

### Environment and equipment

- The main outpatients area had been renovated and updated in recent years, and the environment was safe. It was comfortable and well maintained.
- The resuscitation trolleys were located in one main room. We saw that the equipment was checked daily by the nursing staff, and that records were kept. The equipment was also checked regularly by the hospital's resuscitation team.
- Equipment used in the clinical areas was correctly serviced and maintained, and records were kept. Audits were completed on the servicing of equipment.

### Medicines

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

### Records

- The patient records for each clinic were held in an open trolley. These were not lockable, and there was no lockable storage available in the clinic reception areas. Some staff moved the records into a consulting room when they had to leave the clinic desk. This was not always possible, as a room was not always available. On three occasions, we saw that a trolley of patient notes had been left unsupervised. This meant there was a possibility that patient confidentiality could be breached.
- At some of the clinics we saw that temporary notes for patients were in place. An explanation was supplied with the notes as to why the patient's full set of notes were not available. This was often due to a patient having been seen at another hospital within the previous 24 hours, and there not being enough time to transport the notes.
- Information about patients were also available electronically.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

### Safeguarding

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

# Outpatients

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

## Mandatory Training

- All staff were required to complete a range of mandatory training, which included fire safety, safeguarding, moving and handling, and infection control. All the staff we spoke with told us that they had completed this training, and also any required updates. Staff were aware of their responsibility to ensure they were up to date with mandatory training.
- The manager of the outpatients department was provided with an electronic update on staff whose training was due for renewal.
- Mandatory training was checked as part of staff's annual appraisal process.

## Staffing

- The main reception desk had enough staff to ensure that patients were attended to within a reasonable timescale. The clinics we visited all had their designated staffing levels in place, with the exception of the afternoon orthopaedics clinic, where one health care assistant was working. We were told that generally rotas were organised with additional cover from bank staff when required.

## Are outpatients services effective?

Not sufficient evidence to rate

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

## Evidence-based care and treatment

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

## Patient outcomes

- Staff explained that clinics could become unexpectedly busy for a number of reasons. These included complications in a consultation, delays in getting X-rays or other test results, and additional referrals from the A&E department.

## Competent staff

- Staff we spoke with told us that they had annual appraisals, and we saw that this was monitored by the manager of the department. When appraisals were due, any mandatory training that a staff member needed to complete was also highlighted to the manager.
- We spoke with two healthcare assistants. They said they had been well supported by senior and nursing staff to develop the skills they needed. Staff told us they had regular meetings with their team and supervisors.

## Multidisciplinary working

- Staff told us that they thought the multidisciplinary working was effective, and that skills and knowledge were professionally shared; an example of this was the way in which a dietician supported the diabetes clinic.
- Specialist nurses supported medical staff in some clinics, such as in bariatric clinics.

## Equipment and facilities

- The outpatient area had been updated and renovated in recent years, but due to the increased demand, there were times when additional clinics could not be run because there were no available rooms.

## Seven-day services

- The outpatient service provided a Monday to Friday service, but additional clinics were often run on Saturdays to accommodate the increased demand.

## Are outpatients services caring?

Good

We found that the main outpatients department at Northwick Park Hospital was focused on the patients. We observed staff interacting with patients in a caring and respectful manner. All the patients we spoke with told us that the staff were caring and polite.

# Outpatients

## Compassionate care

- We visited the main outpatients area on two separate occasions and observed staff treating patients with dignity and compassion. Staff responded to questions and queries in a positive and respectful manner.
- We saw staff apologising to patients when clinics were running late, and providing an explanation for delays.
- When all the consulting rooms were occupied, there was not always a private area for staff to discuss matters confidentially with patients and their relatives. We observed a nurse explaining this to a patient and then taking them to quiet area of the waiting room to discuss their next appointment. The nurse also offered to wait until a room became available.
- Staff told us that chaperones were always provided if required, and relatives and friends could accompany patients into a clinic if requested by patients. A consultant confirmed that the staff always provided a chaperone when this was required. Patients we spoke with were aware that chaperones were available, but there was no written information displayed in the waiting area about this service.
- Patients we spoke with told us that the staff were friendly, polite and respectful. One relative accompanying a patient told us “they are all brilliant with my mum because she can get quite nervous”.

## Patient understanding and involvement

- Patients we spoke with told us that they were involved in their care. We were told that the nursing staff and consultants explained things clearly and always answered any questions. One patient told us that they had been a regular visitor for several months, attending two clinics. They told us how they had been involved in discussing changes to their medication, and also the options for future treatment of their condition.

## Emotional support

- Information was displayed in the main waiting area about various support networks or groups that patients could access. Information and directions were also provided for the hospital's prayer room and chapel.
- Patients and relatives told us that they had been given sufficient support by staff when they were given information about their treatment or diagnosis.

## Are outpatients services responsive?

Requires improvement



The outpatients service required improvement to deliver a responsive service to the needs of the patients. The trust had taken steps to implement an action plan to address shortfalls around meeting the 18 week referral to treatment pathways target; however there were a significant number of patients waiting over 18 weeks to be seen. Action taken included staff training, improving processes, and running additional clinics to reduce waiting times. However, some clinics were often overbooked, which meant that there were long waiting times for patients and patients had their appointments cancelled.

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

- Data supplied showed that the trust provided an average of 500 clinics a month for between 27,000 and 33,000 patients. The manager of outpatients told us that demand could outstrip capacity, leading to extended waiting times and delayed appointments.
- In February 2013, the trust identified a shortfall in the 18 week patient referral to treatment (RTT) pathway. Following an internal review action was taken by the trust. A support team from NHS England were engaged to review processes and pathways underlying the 18 week RTT.
- The team undertook a diagnostic review in June 2013, and it established that patient pathways were being incorrectly recorded in some cases. Three areas for action were identified. These were systems and processes, capacity and demand, and culture. An action plan was implemented that included updating of data input, recording and reporting, the development of common pathways that were clear to all members of staff, and the rewriting of the trust patient access policy.
- The department had also set up additional clinics and operating lists to meet a target of treating 95% of patients not requiring an admission, and 90% of patients who do require an admission, within 18 weeks of referral from their GP.
- The trust undertook a review of the patients who had missed the 18 week target, and established that treatments for patients requiring urgent care had not been delayed, and those requiring urgent cancer treatment had not been affected either.

# Outpatients

- When the shortfall in the 18 week pathway had been identified, the trust wrote to and apologised to patients who had waited longer than 18 weeks. The majority of these patients had then been provided with appointments within four weeks.
- Extra clinics were regularly arranged, in conjunction with the specialist departments, to accommodate more patients. Saturday clinics were also sometimes scheduled, such as for urology.
- We were told of work that was being done in conjunction with local GPs, around the planning of X-ray appointments, which would help waiting times for certain clinics.
- The outpatients manager told us that the departments were being asked to do a 'demand and capacity' exercise. This required them to provide information to the manager of the outpatients department on the number of clinics they would need in order to meet the 18 week RTT pathway.
- The manager said that work was being done to investigate the possibility of some clinics moving to Central Middlesex Hospital and also out into community locations.
- The latest overall trust figures for the 18 week RTT pathway were not available at the time of our inspection. However, staff we spoke with believed that for the majority of people this was being met, although there were still long waiting times for certain clinics.

## Access and flow

- There was a patient access centre, where the staff who were responsible for booking and scheduling appointments, and responding to requests for changed appointment times, were located.
- There was a degree of flexibility when patients booked appointments, although this depended on the clinic concerned.
- Clinics could be overbooked and have waiting times of up to two hours. Senior staff told us that this happened regularly for certain clinics, such as orthopaedics.
- The overall percentage of patients who 'did not attend' (DNA) outpatient clinics was between 15% and 16%, which was higher than the national average of 8.5%. Following two missed appointments a decision would be made by the consultant as to whether to refer the

patient back to their GP. Staff we spoke with who were running the clinics told us that they were unsure of the causes of the high DNA rates, and were also unaware of what action was being taken to address the issue.

- A trial had been run using texting to remind patients of their appointments, but the trust had decided not to implement this as a permanent service.

## Meeting people's individual needs

- Access to the main outpatient department was close to the main entrance to the hospital. The area was open and accessible to patients with mobility needs. Directions were clearly signposted.
- Written information was only provided in English, but could be requested in other languages.
- There were systems in place for staff to use an interpreting service. It could be arranged for an interpreter to be present, or accessed via a phone link. We observed staff in the patient access service organising these arrangements at the time of appointments being scheduled.
- Staff explained how they would liaise with carers or relatives to ensure that people with complex needs, such as learning disabilities or dementia, had the appropriate support when they attended clinics. We observed how one older patient, who was being supported by a carer, was prioritised for treatment in the orthopaedic plaster room. This helped ensure that their distress was minimised.

## Learning from complaints and concerns

- Data from the trust showed that there had been no formal complaints made about the outpatients department in the previous 12 months.
- Information about making complaints was displayed in the outpatients area. Senior staff we spoke with were aware of the trust's complaints policy, and the procedure to be followed. Information was also displayed about the Patients Advice and Liaison Service (PALS).
- We observed a healthcare assistant dealing with an informal concern from a patient about an appointment issue. The staff member apologised for any misunderstanding, and asked the patient if they were satisfied with the information they had provided, which they said they were.

# Outpatients

- The general manager of the outpatients department told us they would always try and resolve complaints or concerns informally in the first instance, before referring people to the Patients Advice and Liaison Service.
- Patients we spoke with told us they would be prepared to make a complaint if they felt there was a need.

## Are outpatients services well-led?

Good 

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

### Leadership of service

- Staff we spoke with were positive about the management and leadership provided in the outpatients department. Staff were clear about the lines of responsibility, and who was in charge of the various areas.
- We were told that senior staff were approachable and supportive.

- We saw the minutes from team meetings that showed information and issues within the department were discussed.

### Culture within the service

- All the staff we spoke with were patient-focused. Several staff commented that they wanted to ensure that the patients had a positive experience of the department. They said that they treated people how they expected themselves, and their family, to be treated.
- Patients we spoke with all described the staff as caring.
- Staff told us that they felt able to comment about their role and the department, and make suggestions during team meetings. They also said that they believed they worked well together as a team in order to co-ordinate patient care.

### Public and staff engagement

- Staff were aware of the distribution of trust information via a briefing called 'Team Talk' on the intranet, and also the hospital magazine, which was produced quarterly.
- Several staff had also attended the staff open forums, which had been held in the hospital with members of the trust board. These meetings were held, on average, every three months.

# Outstanding practice and areas for improvement

## Outstanding practice

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

## Areas for improvement

### Action the hospital **MUST** take to improve

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

### Action the hospital **SHOULD** take to improve

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

This section is primarily information for the provider

## Compliance actions

### Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers  People who use services and others were not protected against the risks associated with ineffective decision-making in order to protect their health, welfare or safety. In that:  Very little information was systematically collected on the safety and quality of care and treatment provided within critical care. Regulation 10 (1) (a) (b) (c)(i) (e)  There was a lack of up-to-date protocols and guidelines for staff to work from within surgery. Regulation 10 (1)(b) (2) (b)(iv)  The maternity service did not respond to complaints in a timely manner, nor did it actively seek women's feedback on the maternity pathway. Regulation 10 (1) (a) (b) (2) (b)(i)  The lack of escalation processes in maternity. Regulation 10 (1)(b)

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services  Women who use maternity services at Northwick Park Hospital were not protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of –  Having their individual needs met as comfort checks on the postnatal ward were not regular. Regulation 9(1)(b)(i)

This section is primarily information for the provider

## Compliance actions

Having their safety and welfare ensured because behaviour and attitudes of some midwives towards women fell below expectations. Regulation 9(1)(b)(ii)

### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

### Regulation

Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

People who use services and others were not protected against the risks associated with the safe and suitability of premises in that:

#### **Jack's Place:**

The design of the ward meant that many areas were not observable from the nurses' station, or the reception desk, which posed a safety risk when children were playing in the ward. Regulation 15 (1) (a)

The ward appeared clean, but it was cluttered which meant thorough cleaning could not be achieved. Regulation 15 (1)(c)(i)

The treatment room and store room doors on the ward were left open, potentially allowing access to children. Regulation 15 (1) (b)

On the day of our visit, there were blood samples on a shelf in the open area of Jack's Place awaiting collection, because the pneumatic tube system to take samples to the laboratory was out of order. Regulation 15 (1) (b)

### Regulated activity

Diagnostic and screening procedures  
Surgical procedures  
Treatment of disease, disorder or injury

### Regulation

Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment

People who use services and others were not protected against the risks associated with the safety and suitability of equipment in that:

This section is primarily information for the provider

## Compliance actions

### Jack's place

Not all equipment in the ward was on the trust's asset register, which was why service dates had been overlooked. Regulation 16 (1) (a)

Some electrical equipment did not have PAT testing dates, and trust records showed that on the children's ward 24% of equipment had passed their due date for servicing. Regulation 16(1)(a)

### Neonatal unit

We noted that a fridge in the neonatal unit was iced up and there were gaps in the temperature recording. Regulation 16 (1) (a)

## Regulated activity

## Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

People who use services and others were not protected against the risks associated with the safety and suitability of equipment in that:

There were inadequate staffing levels to provide safe care to patients within the major's treatment area in the A&E department. Regulation 22

There were low numbers of middle grade doctors in general surgery. Regulation 22

Medical staffing levels were very low in critical care. A large number of positions were filled by locums and clinical fellows. The trainees in the department were very junior and unable to take on many tasks independently. Regulation 22