

Imperial College Healthcare NHS Trust Charing Cross Hospital








Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement	
Urgent and emergency services	Good	
Medical care	Requires improvement	
Surgery	Requires improvement	
Critical care	Requires improvement	
End of life care	Good	
Outpatients and diagnostic imaging	Inadequate	

Summary of findings

Letter from the Chief Inspector of Hospitals

Charing Cross Hospital is part of Imperial College Healthcare NHS Trust. It is an acute hospital and provides accident and emergency (A&E), medical care, surgery, critical care, end of life care and outpatient services. These are six of the eight core services that are always inspected by the Care Quality Commission (CQC) as part of its new approach to hospital inspection. The other two core services that are not provided by this hospital are maternity and family planning and services for children and young people.

Charing Cross Hospital has 444 beds and is based in the London Borough of Hammersmith and Fulham. The hospital provides a range of elective and non-elective inpatient surgical and medical services as well as a 24-hour A&E department and outpatient services.

The team included CQC inspectors and analysts, doctors, nurses, experts by experience and senior NHS managers. The inspection took place between 2 and 5 September 2014, with one unannounced visit on 11 September.

Overall, we rated this hospital as 'requires improvement'. We rated effective and caring as 'good' but safety, responsive and well-led as 'requires improvement'.

We rated A&E and end of life care as 'good', but medical services, surgery and critical care as 'requires improvement'. We rated outpatients as 'inadequate'.

Our key findings were as follows:

Safe:

- The hospital was visibly clean and well-lit. Good hand hygiene and other infection control measures were practiced by staff.
- The hospital had sufficient staff for the acuity and dependency of patients in most areas.
- Patients were asked for their consent before procedures were carried out and staff knew how to report concerns related to alleged abuse or neglect.

Effective:

- Policy and protocols were underpinned by national guidelines and there was a single source of guidelines and protocols for staff. The department had also drawn up its own decision tools to aid consistent clinical practice. There was an annual audit plan and audits often led to changes in practice.
- The hospital was the third best performing hospital in the country among the trusts taking part in the Sentinel Stroke National Audit Programme. Pathways used for the assessment and management of patients' medical conditions were informed by appropriate national guidance.
- Clinical staff were competent to carry out their roles and worked well within multidisciplinary teams.

Caring:

- We observed exemplary respectful and kindly interactions with patients that showed genuine concern for patients' wellbeing in the A&E department. The department received a large number of compliments from patients and their relatives.
- Staff interacted well and did their best to make patients comfortable in all areas.
- Patients' privacy and dignity were respected and there were no breaches of single-sex accommodation.
- Patient feedback was mostly positive and staff treated patients with care and compassion.

Responsive:

- There was a process for reviewing complaints and for people to make suggestions for improvement. The hospital took account of patients' views and their feedback was used to improve the service.

Summary of findings

Well-led:

- There was open and effective team working in which staff felt empowered to take responsibility and make suggestions. Where there were problems and emerging concerns, these were escalated to senior management without hesitation.
- The services engaged with patients and staff and their views informed service planning and delivery.
- There was a planned programme of quality measurement and audits taking place throughout the year.
- However, there were also areas of poor practice where the trust needs to make improvements.

The trust must:

- Correct the problems associated with the administration of appointments which was leading to unnecessary delays and inconvenience to patients.
- Address the high vacancy rates for nursing staff and healthcare assistants in some medical wards, and the level medical staffing out of hours for the intensive care unit (ICU) and level 2 beds.

The trust should:

- Take sufficient steps to ensure the 'Five steps to safer surgery' checklist was embedded in practice at Charing Cross Hospital.
- Ensure that all patients who undergo non-urgent emergency surgery are not without food and fluids for excessively long periods.
- Increase the capacity in the outpatients department to address the increased demand and adequately respond to people's needs.
- Assign sole responsibility for the outpatients department to one division so that quality and risk issues could be managed more effectively.
- Meet its target of sending out appointment letters to patients within 10 working days of receiving the GPs referral letter.
- Ensure outpatient letters to GPs occur within its target time of 10 days following clinics.
- Ensure learning from investigations of patient falls and pressure ulcers is proactively shared trust-wide.
- Reduce the backlog of patients who are awaiting elective surgery.
- Increase capacity to ensure patients admitted to the surgical services can be seen promptly and receive the right level of care.
- Avoid cancelling outpatient clinics at short notice.
- Minimise number of out-of-hours transfers and discharges from the medical wards.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating

Good



Why have we given this rating?

The department was well-designed and operated efficiently and safely. We noted a strong culture of learning and improving, both from incidents and from the views of patients.

Staff had received mandatory training including safeguarding. Patients we spoke with were very positive about the care and treatment they received. They said staff introduced themselves, took the time to listen to them and explain any treatment that was required. There was strong, consistent leadership and staff were proud to be working in the A&E department.

Medical care

Requires improvement



We observed a number of hospital discharges taking place after 10pm. Care plans for people living with dementia and diabetes were not used and we noted some patients stayed in the hospital for an excessively long time. There were high vacancy and absence rates among some groups of nursing staff and it was not clear what the senior management was doing to address these. Staff participated in the NHS Staff Survey and the national training survey, organised for trainee doctors.

We found patients were treated with compassion, dignity and respect. Staff were passionate and well-motivated. They had been kept informed of developments at trust level and said managers provided them with good support. We observed examples of very good multidisciplinary team involvement and noted the hospital achieved good clinical outcomes when compared with other hospitals through the use of national audits. The medicines storage and management arrangements were in line with national guidance.

Surgery

Requires improvement



The hospital had not taken sufficient steps to ensure the 'Five steps to safer surgery' checklist was embedded in practice, despite two 'Never Events' occurring elsewhere in the trust in the preceding 18 months.

While there was evidence of good outcomes for patients who underwent surgery, the hospital was not sufficiently responsive to patients' needs. The trust did not provide us with evidence of a plan to

Summary of findings

reduce the backlog of patients waiting for elective surgery nor to deal with patients who had experienced long waits for their surgical interventions.

Surgical wards had low numbers of nursing vacancies; they regularly reviewed the skills mix and used a low volume of agency staff. Patients spoke positively about their care and treatment at the hospital. They told us staff were caring, compassionate and professional.

Critical care Requires improvement



There were issues relating to the medical staffing levels and bed capacity within critical care services at Charing Cross Hospital, although most other aspects of care and treatment were appropriate, with positive feedback from patients. There were also significant audit results that were not supplied to us; the lack of which meant that the hospital could not demonstrate that its critical care services were effective.

Staff were engaged and aware of how the service performed and learnt lessons. Some aspects of training, safety and governance required improvement or change and there was a lack of audit result information.

End of life care

Good



There was an inconsistent approach to the completion of 'do not attempt cardiopulmonary resuscitation' (DNA CPR) forms. Action had been taken in response to the National Care of the Dying Audit for Hospitals 2013, which found the trust did not achieve the organisational majority of the indicators in this audit, but there was no formal action plan. However, the majority of the clinical indicators in this audit were met. In line with national recommendations, the Liverpool Care Pathway for end of life care had been replaced with a new end of life care pathway framework that had been implemented across the hospital. There was a recently developed end of life strategy and identified leadership for end of life care. The end of life steering group reported to executive committee. The SPCT were visible on the wards and supported the care of deteriorating patients and pain management. Services were provided in a way that promoted patient centred care and were

Summary of findings

responsive to the individual's needs. Referrals for end of life care were responded to in a timely manner and the team provide appropriate levels of support dependent on the needs of the individual. There was clear leadership for end of life care and a structure for end of life care to be represented at board level through the director of nursing.

Outpatients and diagnostic imaging

Inadequate



Full patient records were not always available to support consultations in clinics. The responsiveness of the department was particularly poor. The number of clinics had not increased in the last year despite an increase in patients. As a result, patients were having to wait longer to get an initial appointment and also had longer waits to be seen when in clinic. Doctors consistently turned up late for clinics without explanation. Managers we spoke with were unable to set out the process by which they monitored performance and made improvement plans.

The hospital was not meeting its target of sending out appointment letters to patients within 10 working days of receiving the GP's referral letter, which we heard could take between three and five weeks. There were several problems associated with the issuing of appointment letters which caused unnecessary delay and inconvenience to patients. However, there were enough nursing and medical staff in the department. Patients were treated with compassion, dignity and respect, and they were positive about the care they received. Staff were focused on providing a good experience for patients and treated them with care and compassion.

Requires improvement 

Charing Cross Hospital

Detailed findings

Services we looked at

Accident and emergency; Medical care (including older people's care); Surgery; Critical care; End of life care; and Outpatients

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Detailed findings

Background to Charing Cross Hospital

Charing Cross Hospital is a general acute hospital and part of Imperial College Healthcare NHS Trust. It has 419 beds. This CQC inspection was not part of an application for foundation trust status.

Charing Cross Hospital is in the London Borough of Hammersmith and Fulham, which is an inner-city borough located in West London. The borough has

pockets of deprivation with a deprivation score of being placed 55 out of 326 local authorities. Life expectancy for men is slightly lower and for women it is slightly higher than the England average.

Charing Cross Hospital is one of five Imperial College Healthcare NHS Trust locations. The trust also provides services from St Mary's Hospital, Hammersmith Hospital, Queen Charlotte's & Chelsea Hospital and the Western Eye Hospital.

Our inspection team

Our inspection team was led by:

Chair: Peter Wilde, Consultant, MRCP FRCR

Head of Hospital Inspections: Heidi Smoult, CQC

The team of 53 included CQC inspectors and analysts and a variety of specialists: consultants in emergency

medicine, medical services, gynaecology and obstetrics, palliative care medicine; consultant surgeon, anaesthetist, physician and junior doctor; midwife; surgical, medical, paediatric, board level, critical care and palliative care nurses' a student nurse; and experts by experience.

How we carried out this inspection

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

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

The inspection team inspected the following core services at Charing Cross location:

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

Please note: The two core services that are not provided by Charing Cross Hospital are maternity and family planning and services for children and young people. These services are assessed in our reports for the other Imperial College Healthcare NHS Trust hospitals.

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group; NHS Trust Development Authority; Health Education England; General Medical Council; Nursing and Midwifery Council; Royal College of Nursing; NHS Litigation Authority and the local Healthwatch.

We carried out an announced visit between 2 and 5 September 2014 and an unannounced visit on 11 September 2014. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. 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.

The CQC inspection model focuses on putting the service user at the heart of our work. We held a listening event in the London Borough of Hammersmith and Fulham on 2 September 2014, when people shared their views and experiences of Imperial College Healthcare NHS Trust.

Facts and data about Charing Cross Hospital

Key facts about Charing Cross Hospital

Charing Cross Hospital is one of the five registered acute hospital locations of Imperial College Healthcare NHS Trust.

Context

- Around 444 beds
- Serves a population of around 182,500
- Employs around 2,399 whole time equivalent (WTE) members of staff

Activity

- Around 254,665 outpatient attendances per annum
- Around 19,549 A&E attendances per annum

Key Intelligence Indicators

Safety

- One Never Event in last 12 months – wrong site surgery in surgical services (orthopaedics)
- Serious untoward incidents: There were 27 serious untoward incidents between April 2013 and March 2014

Effective

- Hospital Standardised Mortality Ratio (HSMR) indicators – 74.28 (better than the national average)

Caring

- NHS Friends and Family Test – average score for A&E was better than the national average but for inpatients it was worse for 2012/13
- Response rates for both inpatients and A&E were better than the national average for 2012/13
- Cancer Patient Experience Survey – in the bottom 20% of all trusts nationally for 55 of the 69 questions
- CQC Adult Inpatient Survey – the trust scored ‘within expectations’ in 11 out of 12 areas

Responsive

- A&E, four-hour target – met the 95% target in the previous 12 months
- Referral to treatment times – met the admitted and non-admitted pathways target times
- Cancer: two-week wait – met the national target
- Cancer: 31-day wait – met the national target
- Cancer: 62-day wait – did not consistently meet the national target

Inspection history

- One previous dementia thematic inspection in January 2014 prior to the publication of ratings.

Detailed findings

Our ratings for this hospital




Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Not rated	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

1. We have not inspected maternity and children and young people services, because these services were not provided at Charing Cross Hospital.
2. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for A&E and Outpatients.

Urgent and emergency services

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

Information about the service

The accident and emergency (A&E) department at Charing Cross Hospital is open 24 hours a day, seven days a week. The A&E department, including the urgent care centre (UCC), sees about 79,000 patients a year, mainly from West London, of which 35,000 adult patients require acute care. There is a five-bay resuscitation area, 12 cubicles for assessment and treatment and a 10-bed area used flexibly as a clinical decision unit (CDU) and a medical assessment unit (MAU).

Charing Cross Hospital has a hyper acute stroke unit (HASU) so stroke patients coming in by ambulance are often brought to the hospital. Since April 2014 the department has not been a trauma centre. It also does not generally treat gynaecology or maternity patients or children. A few patients in these groups arrive independently and are stabilised and, if necessary, transferred.

There is a single point of access reception for patients who come in independently which directs patients into A&E or the UCC.

Around 43,000 adults and children attend the UCC, seeking treatment for minor injuries or to be reviewed by a GP. The UCC is run by Partnership for Health, a consortium of Imperial College Healthcare NHS Trust, Central West London Community Services and London Central & West Unscheduled Care Collaborative. This service was not inspected other than to explore care pathways between this service and the A& E department. The UCC is open 24 hours a day, seven days a week.

During our inspection, we spoke with clinical and nursing leads for the department, five doctors and eight nurses at different levels, and three other staff members. We also spoke with 15 patients and visitors. We undertook observations within all areas of the department and reviewed documentation, including patient records.

Urgent and emergency services

Summary of findings

The standard and quality of care provided by the A&E department was good overall. The department was well-designed and operated efficiently and safely. We noted a strong culture of learning and improving from incidents and from the views of patients.

Staff had received mandatory training including safeguarding. Patients were spoke with were very positive about the care and treatment they received. They said staff introduced themselves, took the time to listen to them and explain any treatment that was required. There was strong, consistent leadership and staff were proud to be working in the A&E department.

Are urgent and emergency services safe?

Good



The safety of the care provided at the A&E department was good. The department was visibly clean and well-lit. Good use was made of the available space and clinical staff had clear sightlines to patients which supported safe care. We observed good hand hygiene and barrier nursing when appropriate. Paediatric, trauma and gynaecology equipment was kept on site for the infrequent occasions when they may be required. We noted that less frequently used equipment needed to be checked periodically to make sure items had not passed their expiry date. The department had sufficient staff for the acuity of patients.

Incidents

- There had been one serious incident in the past year. Following that incident, all doctors and nurses had been trained in the variable presentation of aortic dissection (a condition in which there is bleeding in the main artery leading to the heart). Subsequently, one of the nurses was able to diagnose this condition in a patient.
- Staff told us that incidents were regularly reported through the hospital's internal reporting system and generally received feedback on the outcome.
- Junior doctors reported that an hour of their protected weekly teaching was dedicated to case presentations based on learning from incidents.
- Mortality and morbidity meetings were held quarterly. Learning was drawn from these and, where appropriate, action plans were developed to change practice. Changes were shared widely with staff.

Cleanliness, infection control and hygiene

- The A&E department appeared visibly clean and was well-lit.
- Clinical and non-clinical staff were using antibacterial gel which was well-positioned in the department and at the end of each trolley or bed. We observed hand washing in line with the Royal College of Nursing guidelines.
- Disposable gloves and aprons were readily accessible to staff needing them. We saw staff using this protective equipment before entering a bay and removing it prior to leaving.

Urgent and emergency services

- Staff told us it was easy to escalate concerns regarding cleanliness or repairs to estates and management, and they were responsive. Regular checks were made on equipment to ensure it was clean and in good working order.
- London Ambulance staff reported that Charing Cross Hospital was always clean, tidy and ready for the ambulance, even though it was often very busy.
- Curtains around cubicles were seen to be dated August or September 2014 indicating that they were regularly changed.
- Staff wore clean uniforms with name badges indicating their titles, and all were 'bare below the elbows' in line with good hygiene practice.
- Cleaning rotas were displayed on the wall and were up to date and accurate.
- MRSA infection data was not collected in A&E. The trust's policy was that patients who were admitted and stayed over 24 hours were screened for MRSA. Therefore, MRSA screening was the responsibility of the receiving ward.
- There was flexible use of the space used both as a CDU and MAU, with separate male and female areas.
- The ambulatory care unit was well-lit providing a pleasant environment for patients attending.
- The psychiatric holding room had fixed sofas as a safety measure. It had two doors and was well-lit. There were no ligature points. There was some dirt visible underneath the fixed furniture which was a difficult area to clean.
- In case a trauma patient was brought into the department, appropriate equipment was kept in a sealed cupboard. We saw that it contained an out-of-date trauma list.
- Equipment, drugs, age-related drug charts and guidelines for paediatric resuscitation were kept ready for use in one bay in case a child was brought in.
- On the emergency obstetric trolley we found cord clamps and swab diluent that were two months out of date
- The flooring was worn on the route to x-ray.

Environment and equipment

- The handover space for patients coming in from ambulances was well laid out. The nurse in charge, receptionist and specialist registrar were all near and at hand. There was sufficient privacy for handover discussions with paramedics.
- The resuscitation bays were spacious and clean. Resuscitation equipment was in clearly ordered storage, consistent in each bay. Staff told us there was always enough equipment available.
- We were told that the demand for resuscitation beds was such that more than once a week a resuscitation patient had to be moved into the major injuries (Majors) area. In this instance, monitored beds nearest to staff were used and staff were accustomed to managing this situation.
- Treatment cubicles were clean and well-equipped with appropriate lighting.
- The workspace was efficiently planned and effective, making good use of the available space. Doctors and nurses confirmed the environment was excellent to work in with good sightlines to patients which supported safe care.
- There were side rooms which could be used, for example, if a person needed more private care or for patients who might be infectious.

Medicines

- There was well-organised medicine storage and efficient stock control. A pharmacy technician checked medications three times a week. Controlled drugs were checked twice daily by two nurses.
- Patient prescription charts were completed and signed by the prescriber and nurse administering the medication.

Records

- We looked at 10 sets of patient notes during our inspection. These had completed patient observations and regular reassessments were recorded. Patient notes were kept securely.
- Documentation audits were carried out and any issues identified would be shared with staff to promote improvement.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- We observed nursing and medical staff asking patients for consent before carrying out examinations or procedures.
- Staff we spoke with demonstrated a reasonable understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). This A&E department saw a relatively high proportion of elderly

Urgent and emergency services

and mental health patients so they were accustomed to working with them. A registered mental health nurse was employed in the department to work with relevant patients.

- Statutory and mandatory training attendance by staff in A&E was about 70% overall, and MCA awareness was included in such training.

Safeguarding

- Staff were trained in safeguarding to the appropriate level. Those we spoke with knew how to spot signs of domestic violence, abuse or neglect in children and adults and how to report it.
- There was access through St Mary's paediatric A&E for a senior paediatric and senior emergency medicine opinion 24 hours a day for child welfare issues.
- A health visitor was linked to the department and was notified of children brought into A&E, and of parents of children who had mental health issues, or were subject to domestic violence.
- Patients entering the treatment area after triage had to walk through the staff work station area. There was a small risk that they might see confidential data on computer screens or overhear telephone conversations. Staff were aware of this but there were limited options for where triage could take place and still have easy flow into the clinical area and the current arrangement was the best option.

Mandatory training

- In the year to March 2014, compliance with statutory and mandatory training in the A&E at Charing Cross was 62% for all staff. This was below the trust's target of 95%. Managers monitored compliance and encouraged staff to undertake mandatory training.

Assessing and responding to patient risk

- Patients arriving by ambulance were rapidly assessed by the designated clinician and a nurse as near as possible to their arrival. Patients arriving as a priority call were transferred immediately to the resuscitation area. These were often stroke patients.
- Patients arriving independently were assessed by the GP in the UCC. Triage of patients referred to A&E was carried out by a senior nurse and the order patients were seen depended on the acuity of their condition. The UCC

triaged about 62% of patients within their target of 15 minutes. This timing was not within the control of the A&E department. Children were seen immediately by a senior nurse.

- The National Early Warning Score (NEWS) system was used effectively and clinical observations were entered into patient notes. The escalation processes for a deteriorating patient were clear.
- Risk assessments, for example, for falls, were used as appropriate.

Nursing staffing

- Staffing was sufficient for the acuity of patients, even though one nurse was off sick. In that situation, we were told that the matron, who was supernumerary, would help out clinically as needed. We noted there had been one incident report in July that related to inadequate staffing.
- At night there were seven nursing staff on duty. Three additional band 5 nurses were joining the A&E to cope with the expected increase in pressure following the closure of the A&E at Hammersmith Hospital.

Medical staffing

- The College of Emergency Medicine (CEM) recommends 10 whole time equivalent (WTE) consultants per emergency department. In this department there were six WTE consultants. Consultant cover was from 8am to 8.30pm Monday to Friday and six hours a day at weekends (11am to 5pm). There were six regular locums at the middle grade, and as they worked regularly at the hospital, they were familiar with the department and protocols.
- At night there was a registrar and two junior doctors on duty which met national guidelines. The clinical lead considered there was a safe level of staffing at night. A consultant was on call out of hours.
- Three additional core medical trainees were being added to the acute medical team working across medicine for the elderly, ambulatory care and acute medicine to relieve extra pressure on the A&E following the closure of the A&E at Hammersmith Hospital.
- Junior doctors expressed concern about the sometimes slow response of doctors in particular specialities, such as oncology.
- From 11am to 7pm one doctor was designated to carry out rapid assessments on ambulance patients.

Urgent and emergency services

Agency and bank

- Agency and bank staff use for all staff was 9% in July 2014. The vacancy rate was 10%. The sickness rate for the past 12 months averaged 4%. We saw an induction checklist used for agency staff, with explicit information about expectations of the role(s), and where to find information on the intranet if needed. Staff were required to check temporary staff photo ID on arrival. There were very clear and structured handovers which helped make everyone's role clear.

Security

- Staff reported that security at Charing Cross Hospital was good and there was always sufficient support available when required.

Major incident awareness and training

- We saw a 2012 major incident plan and notices around the department relating to major incident response. This plan needed to be updated to take account of the changes to A&E at Charing Cross (the hospital was no longer taking trauma patients). We noted a board in the staff work area for recording patient tracking information in the event of computer failure.
- There was an updated business continuity plan dated July 2014.

Are urgent and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Policy and protocols were underpinned by national guidelines and there was a single source of guidelines and protocols for staff. The department had also drawn up its own decision tools to aid consistent clinical practice. There was an annual audit plan and audits often led to changes in practice.

Evidence-based care and treatment

- Departmental policies were based on National Institute for Health and Care Excellence (NICE) or CEM guidelines and were easily accessible from a single electronic source where the A&E department had drawn together all relevant A&E guidelines. We looked at guidelines for severe sepsis, non-invasive ventilation and pulmonary embolism which were clear and current.

- All paper forms were also available on the hospital's intranet so only up-to-date versions were used.
- The department had drawn up its own clinical decision support tools which doctors said were valuable.
- We saw examples of local and national audits, including the audit plan for the year. Each trainee doctor carried out an audit every four months.
- We saw an annual audit programme and looked at local audits of venepuncture (the process of accessing the vein for medication or for blood sampling), Waterlow risk assessment scores (showing the risk of pressure ulcers) and time to electrocardiogram (ECG) to measure heart rhythms. These were all used to improve care to patients.

Pain relief

- We reviewed pain documentation and concluded that it was consistently monitored and measured. Appropriate medication was prescribed for different pain scores and prescriptions were clear.

Nutrition and hydration

- There was tea, coffee and water available for patients in the main department. The department ensured that patients who had long waits or missed mealtimes were offered sandwiches and snacks.

Patient outcomes

- Results of CEM audits were used to assess the effectiveness of the department. For example, where the renal colic audit 2012/13 had shown the department had performed less well in some areas than in the previous audit, there were plans to address this.
- The CEM 2013 audit of consultant sign-off showed that Charing Cross Hospital had a very low percentage of patients seen and signed-off by a consultant or associate specialist.
- The percentage of people re-attending the department within seven days was high at 8.3%. The CEM recommended that trusts should aim for less than 5% re-attendance.

Competent staff

- Doctors considered they had adequate exposure to minor injury and trauma patients through planned rotation into St Mary's A&E department. Trauma and paediatric simulations were run to enable them to maintain their skills. Both were filmed and critiqued in real time and staff found them a valuable learning experience.

Urgent and emergency services

- Staff reported that the appraisal system worked well and encouraged people to develop their skills. The appraisal rate for staff was about 78%.
- The induction information for new doctors was regularly reviewed. Locum and new staff received a Charing Cross Hospital specific induction so they knew their surroundings and local procedures.
- There was training for doctors away from the department every Thursday morning.

Multidisciplinary working

- There was a structured multidisciplinary team handover at 8am using a set agenda covering issues from overnight, local and trust-wide capacity, equipment needs and restocking, safeguarding, operational changes or new policies and teaching points. This system was efficient, emphasised holistic care to patients and boosted team working. All staff were encouraged to speak up and raise questions. Staff considered it a good opportunity to learn from colleagues.
- We noted a good example of patient follow-up after a morning multidisciplinary team meeting. The review of a patient discharged the previous evening led to that patient being immediately referred to specialist services at Hammersmith Hospital.
- Staff said they believed the skills mix to be effective and we observed good team working.
- Staff were aware of the key contacts in other hospital teams and the protocols to follow. Staff said the relationship with the intensive care unit worked effectively.
- Local drug and alcohol teams and advocates for homeless people could be contacted to support patients as needed.
- Access to psychiatric input for relevant patients was good; and was via an employed registered mental health nurse and the psychiatric liaison team. Although psychiatric input was not yet available 24 hours a day, the trust had plans in place and was working towards achieving this.

Seven-day services

- Most services operated seven days a week but discharge nurses and occupational therapists were only available Monday to Friday.

Are urgent and emergency services caring?

Good



Patients received a caring service at the A&E department. The department had very positive NHS Friends and Family Test results. We observed exemplary respectful and kindly interactions with patients that showed genuine concern for their wellbeing. The department received a large number of compliments from patients and their relatives.

Compassionate care

- We observed numerous instances of very high-quality interaction with patients, including when staff were unaware they were being overheard. Nurses listened carefully to patients, and spoke to them with sensitivity. They enquired if patients would like chaperones and sought patients' consent to being examined.
- Nurses checked patients regularly to ensure they were comfortable and responded quickly if patients asked for help. There was hourly rounding on the CDU/MAU.
- Patients who had been admitted to the hospital through A&E said they were very pleased with the level of care and support they had received there.
- 60 patients responding to the NHS Friends and Family Test score in June 2014 would be extremely likely to recommend the service. The response rate was 25%. The department also used electronic survey devices that allowed them to continually gather patient feedback and see the results in 'real time'. This showed mainly positive feedback.
- Staff worked hard to ensure patients' privacy and dignity was always maintained. We saw staff drawing curtains round cubicles as patients were admitted.

Patient understanding and involvement

- Patients told us they appreciated that clinical staff introduced themselves and wore name badges. They said the staff explained what was happening and what the next steps would be. They also said they trusted staff to make sure everything went as planned.
- We observed a sensitive discussion with family members about care of their relative.

Urgent and emergency services

Emotional support

- Patients told us staff listened to their concerns and provided them with reassurance. We observed staff providing patients and relatives with emotional support where appropriate.

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

Good



The department was responsive to people's needs. There was a process for reviewing complaints and suggestions for improvement. The department was equipped to provide for patients with a range of conditions, including where there were not services on site such as for children or patients with gynaecological conditions. Patient feedback about their experience was positive, although triage through the UCC was sometimes slow.

Service planning and delivery to meet the needs of local people

- Stroke patients from across North West London were brought by ambulance to A&E for thrombolysis (breaking down of blood clots) before being transferred to the linked HASU. There was a well-established system for managing these patients.

Waiting times

- Nationally agreed emergency department quality indicators state that 95% of patients should be seen, treated, discharged or admitted within four hours. On 1 September 2014, 98% of adults were treated within the recommended time, (the average for the week had been 94%). There had been one breach of a type 1 case that week (type 1 are the most seriously ill patients). Staff told us that the reasons for breaches were almost invariably shortage of beds in the main hospital. Another cause was late referral from the UCC. The hospital recorded breaches and monitored these daily.

Access and flow

- Charing Cross Hospital's performance for speed of ambulance handover to A&E was 91.9% within the target of 15 minutes, 96.5% within 30 minutes in the week of 11 August 2014.

- Senior staff knew how to respond to periods of high demand. For example, on an afternoon that had 11 ambulances in a short time period, the senior nurse alerted the ambulance service to the situation at the department.
- Where Charing Cross Hospital did not have the right services to follow up patients, they were transferred to either Hammersmith or St Mary's hospitals. For example, 23 patients were transferred for orthopaedics, 13 for surgery and seven for gynaecology over the past seven months. A new role of pathway coordinator was being established to help patient flow.
- There were clear protocols for transfer to the CDU. The average length of stay on the CDU was 19 hours. Any patient who had been on a trolley for more than six hours was automatically transferred to a bed in the CDU.
- Bed occupancy at Charing Cross Hospital was high: 89% on 1 September 2014. Capacity was to increase by 16 beds to help with the flow of patients following the closure of Hammersmith Hospital A&E.
- Since April 2014, 3.5% of patients had waited between four and 12 hours after a decision had been made to admit.
- On average, 1.8% of patients left A&E without being seen by a doctor or nurse which is within the quality threshold of 5%.
- Patients with long-term conditions – for example, haematology, cardiac or renal patients – were given 'patient access cards' with a number to call if they thought they needed urgent treatment or to show to the London Ambulance Service in an emergency. This would ensure treatment at the appropriate location and was intended to take pressure off A&E.
- About 40% of patients coming into A&E were admitted. Most of the admitted patients were elderly.
- There were next-day ambulatory care pathways for those with renal colic or deep vein thrombosis.

Meeting people's individual needs

- A telephone translation services was available and we saw leaflets in multiple languages in the waiting room that explained how to access this. Some staff were also able to translate for patients.
- The waiting room contained multiple leaflets on a range of conditions and services in well-placed dispensers.
- A high proportion of patients coming to A&E at this hospital were older people. The emergency department had recently opened new services for frail, older people

Urgent and emergency services

such as a consultant-led older persons rapid access clinic with multidisciplinary and community support. There was also a joint memory and falls clinic. Older people with a Glasgow Coma Scale (a measure of alertness) score of 15 and able to care for themselves were discharged from A&E, but if they needed further tests they could attend the rapid access clinic the next day.

- We observed treatment of a patient with complex medical needs who had been in the department 2.5 hours. The patient was complimentary about their care in this department, pleased at the way staff introduced themselves and impressed by the speed of treatment. The patient had been offered pain relief and food and drink but declined.
- The mental health cover was soon to be 24-hours a day, seven days a week in response to the closure of the local mental health walk-in service.
- Staff acknowledged that the prompt care of mental health patients had been a challenge since the nearby walk-in centre for mental health patients had closed. The department now had a registered mental health nurse on duty each day who looked after patients until they could be assessed by the psychiatric liaison service. Patients might have waited an hour for assessment in working hours and longer outside this time when the liaison service was on call. The department had submitted a business case for the liaison service to be 24 hours a day to provide a better service to patients with mental health needs.
- The psychiatric holding room was near to the ambulance entrance. Staff were aware of the risk that patients might abscond, but said that there were good sightlines to the door from the nurses' station.
- Up-to-date staff names and photographs were on the noticeboard to help patients identify who was treating them.
- Discharge arrangements were clear. Staff reported there were delays for people requiring hospital transport, but this was outside their control.
- The relatives' room was in a quiet area, pleasantly furnished and with magazines to read.
- The beds in the CDU/MAU were not for patients needing electronic monitoring. We observed that a patient at risk, such as a person living with dementia, was placed nearer the nurses' station so staff could observe them.

- There were some homeless people in the borough and there were advocacy services available to help with their needs.
- There was a follow-up clinic for people with alcohol dependency and ready access to advisory services.
- There was clear signage throughout the department to enable people to find where they wanted to go.
- Leaflets on a range of topics were on display and easily accessible, for example, on the Patient Advice and Liaison Service (PALS), physical and mental health conditions, and bereavement.
- Although children were not brought by ambulance because Charing Cross Hospital had no paediatricians on site, there were times when parents did bring their children because they were unaware that paediatric services were unavailable. Such children were assessed and stabilised immediately and, if necessary, transferred by ambulance to a paediatric unit for specialist treatment.
- All doctors wore scrubs in the colour appropriate to their grade so they were clearly identifiable and there were pictures to help patients identify staff roles. Patients told us they found this helpful.

Learning from complaints and concerns

- The department promoted PALS, which was available in the hospital and there was information on how to raise concerns.
- There were few complaints from patients and relatives, but those received were responded to quickly. Complaints were reviewed quarterly to identify trends.
- Patient feedback about their experience was positive. We saw evidence that there were three times more compliments than complaints. A database of patient feedback was held in the department.
- We saw a good example of response to a complaint received from a GP about patient care. There was a full apology, a promise that the incident would be followed up with the staff responsible and the case would be used for teaching junior doctors.

Urgent and emergency services

Are urgent and emergency services well-led?

Good



Leadership of A&E was consistent and visible. Key information was discussed at divisional board level and reported to the Trust Board. The department took learning from cases and incidents seriously. There was open and effective team working in which staff felt empowered to take responsibility and make suggestions. Staff exhibited high morale, pride in their work and a drive to give a positive experience to patients.

Vision and strategy for this service

- The medium-term plan was for the department to merge with the emergency department at St Mary's Hospital, but not until that facility was rebuilt. In the meantime, the department sought to offer patients the best possible care.
- The department had put forward a well thought out case for closer links with the UCC to increase staff flexibility across the whole emergency service and prevent delays caused by slow streaming processes (where patients are directed to the most suitable service).

Governance, risk management and quality measurement

- The A&E was part of the medicine division. Key information on issues such staffing, training, incidents and risks from monthly meetings of the medicine division management board were reported to the trust board.
- The risk register for A&E was part of the register for medicine. Appropriate mitigating action was being taken on identified risks.
- A daily situation report came around to the department's managers summarising the department's activity and performance and the previous day's activity. This enabled managers to oversee key indicators and monitor safety and effectiveness. Weekly summaries were circulated to all A&E managers.

Leadership of service

- There was clear leadership for both medical and nursing staff. The lead consultant and matron worked closely

together. They were both visible in the department and clearly respected by staff. Staff told us there had historically been effective leadership at this site. We saw evidence of strong and motivated team working.

- Staff roles were clearly defined and all staff were aware of their own and others responsibilities.
- The department took learning from cases and incidents seriously. These were discussed daily in the morning handover meetings and through the mortality and morbidity meetings.
- Staff were involved in the planning for the department to manage the impact of the closure of Hammersmith Hospital A&E on 10 September 2014. Additional staffing had been agreed.

Culture within the service

- There was open and effective team working in which staff felt empowered to take responsibility and make suggestions. Several staff mentioned the "no blame" culture.
- There was priority given to dissemination of information and training.
- Staff exhibited high morale, pride in their work and a drive to give a positive experience to patients. Staff in other parts of the hospital commented that A&E seemed to be one of the happiest departments to work in.




Public and staff engagement

- Junior doctors reported they had reliable consultant support out of hours and staff were supportive and approachable.
- There was a strong drive to use patient information to improve the service. All staff had a target of seeking feedback from two patients per shift.
- There was confusion among members of the public about the future of Charing Cross Hospital and when it might close. Several patients and family members asked us about this.
- A monthly newsletter was produced to keep staff informed of work and social events, in addition to the monthly medicine update.

Innovation, improvement and sustainability

- A number of initiatives had been instigated to try to keep people out of hospital and at home or using community care, particularly for the local older population.

Medical care (including older people's care)

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

Information about the service

Medical services at Charing Cross Hospital include acute medicine wards, care of the elderly wards, specialist wards such as oncology, cardiology and neurology and the stroke unit. The hospital hosts one of eight hyper acute stroke units (HASUs) in London.

During our inspection we visited 10 medical wards. We spoke with 20 patients and four of their carers and relatives. We met with 46 members of staff including doctors, nurses, and allied healthcare professionals, ward managers, senior staff and other support staff, such as cleaners and ward clerks. We reviewed patient and medication records and observed care being delivered on the wards.

Summary of findings

We observed a number of hospital discharges taking place after 10pm. Care plans for people living with dementia and diabetes were not used and we noted some patients stayed in the hospital for an excessively long time. There were high vacancy and absence rates among some groups of nursing staff and it was not clear what the senior management was doing to address these. Whilst staff participated in the NHS Staff Survey and the national training survey, organised for trainee doctors, there was not detailed information on how the medical services performed.

We found patients were treated with compassion, dignity and respect. Staff were passionate and well-motivated. They had been kept informed of developments at trust level and said managers provided them with good support. We observed examples of very good multidisciplinary team involvement and noted the hospital achieved good clinical outcomes when compared with other hospitals through the use of national audits. The medicines storage and management arrangements were in line with national guidance.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement 

Not all patients' records were appropriately completed and fit for purpose. Patients were asked for their consent before procedures were carried out. Staff knew how to report concerns related to alleged abuse or neglect. Procedures used for reporting errors, incidents and near misses were effective. However, not all of the staff working in the hospital had completed their mandatory training and there were high vacancy rates in some areas among nursing staff and healthcare assistants.

Incidents

- Incidents were reported, learning was mostly identified and they were discussed in ward meetings. Reported incidents were assigned to an appropriate service lead for investigation. We observed in some closed cases the incident investigation outcomes or lessons learnt sections were not recorded. In 2013/14, 46 incidents were reported in the medical division through Strategic Executive Information System used for reporting serious untoward incidents. We did not have information about what number of these incidents related to Charing Cross hospital. Staff were aware of the most recent safety alerts which were relevant to their specialities and took action where appropriate.
- Patients' deaths were adequately reviewed. Mortality and morbidity meetings took place at speciality level and concerns identified were reported through the directorate committee meetings. There were no standardised written records from those meetings.

Safety Thermometer

- We saw that information related to the NHS Safety Thermometer – a tool designed for frontline healthcare professionals to measure harm to patients, such as falls, pressure ulcers, blood clots, urinary tract infections and venous thromboembolism (VTE or blood clots) in adults – was displayed on most of the medical wards. Staff were aware of their responsibility to reduce incidents such as falls and pressure ulcers.
- Staff had good access to tissue viability services. All grade 3 and 4 pressure ulcers were investigated and

areas for improvement were identified post investigation. Grade 2 pressure ulcers were also monitored and analyses were undertaken in order to identify causes, trends and patterns.

- There was a high number of falls (22) on Ward 9 West since June 2014 when compared with other wards at the hospital.
- More than 95% of patients were assessed for the risk of VTE within 24 hours of admission to hospital. All patients suffering a hospital-acquired VTE were subjected to a formal root cause analysis with the responsible clinician. There was a VTE lead allocated for the trust.

Cleanliness, infection control and hygiene

- Staff responsible for cleaning knew of measures they should take to reduce the risk of healthcare-associated infections. Patients with suspected or confirmed healthcare-associated infection were nursed in side rooms.
- We noted that hand hygiene practice was appropriate. There were hand-washing facilities in every room and hand gel dispensers throughout the hospital and near patients' beds. Weekly hand hygiene and cleaning audits, which took place on each of the wards, indicated compliance levels above 95%. Staff used personal protective equipment when appropriate, such as gloves and aprons.
- An infection control nurse visited wards weekly to monitor infection prevention and control practice and environment issues. Outcomes of those visits were shared with matrons by email and the nurse told us they were discussed at staff meetings.
- There was low MRSA screening compliance rate in the hospital of around 76% across all medical wards since April 2014. None of the four patients who were to be tested for MRSA on Lady Skinner Ward since April 2014 had been tested. However, three of the four cases on Ward 9 South were tested. Wards 6 South and 8 South reported over 90% MRSA screening compliance for the same period.

Environment and equipment

- Equipment used on medical wards was clean and labelled to indicate it was disinfected and ready to use. Disposable equipment was also easily available, in date and appropriately stored.
- Resuscitation equipment was easily accessible to staff and it was checked regularly. There was other

Medical care (including older people's care)

equipment, such as oxygen cylinders and fire safety equipment, available to deal with unforeseen incidents. It was checked and labelled correctly to indicate it was ready to use.

- Some patients commented on the wheelchairs used to transfer patients across the hospital which they said seemed “old and worn”.

Medicines

- Medicines were managed and stored appropriately on most of the wards. They were kept secure and were in date. When medicines were refrigerated, the fridge temperature was in the safe range and checked daily.
- When patients missed their medication it was clearly recorded and reasons were documented in their record.
- On Ward 9 South some skin disinfectants were out of date, one since August 2010 another one since October 2013. It was brought to the attention of a senior nurse on the day of the inspection. On the same ward a large box with a stock of unused medicines, which were to be disposed of daily, was awaiting collection for number of days. One emergency medicine could not be found after it had been temporarily transferred to another ward.
- Patients who were self-medicating had access to secure side cabinets. On one ward, lockers were old and they did not lock. However, new lockable side cabinets on another ward were waiting to be installed.
- Resuscitation trolleys contained all necessary equipment and were checked daily on all of the wards.
- Staff told us the pharmacy services were easily available and pharmacists visited the wards daily. Staff were able to contact the pharmacist when required.
- The hospital pharmacist told us a pharmacy technician checked stock levels, expiry dates and replaced drugs both in the cupboards and fridges three times a week. The hospital pharmacist also said controlled drugs were checked twice daily by two trained nurses to ensure the levels were correct. These checks were recorded in accordance with statutory requirements. Pharmacists carried out checks of controlled drugs management twice a year on all clinical areas that stocked them. No concerns were highlighted about these checks in the past year.

Records

- All staff were aware of the confidentiality and data protection policies and procedures. Information governance training was mandatory for all staff working

at the hospital. This was to ensure staff had knowledge related to the appropriate use of information. Nurses and healthcare assistants confirmed they had completed this training.

- The patient records and observation charts we checked showed that most assessments had been completed, including nutrition assessments, skin integrity assessments, National Early Warning Scores (NEWS) and falls assessments. We noted some patients' risk assessments were not fully completed on Lady Skinner Ward, for example, for falls and manual handling.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- Staff were aware of their responsibilities in obtaining consent from patients as well as carrying out a best-interest assessment if someone did not have capacity to make specific decisions.
- The records we reviewed showed patients had consented to the treatment they were receiving and the forms were clear and easy to understand.
- At the time of our inspection, there were no patients who had been subject to deprivation of liberty safeguards. However, staff were knowledgeable about applying the relevant safeguards.

Safeguarding

- Staff we spoke with were aware of their requirements to report suspicions of abuse involving vulnerable adults and were aware of the safeguarding lead for the trust. We were given examples of when they had contacted the safeguarding lead when they had a concern.
- Staff said they had received training in safeguarding vulnerable adults and nurses had been appropriately trained up to level 2.

Mandatory training

- The trust reported that most of the doctors working within elderly medicine, oncology, acute medicine, and endocrinology, were up to date with their mandatory training. However, while the trust's target for mandatory training compliance was 95%, only 67% of doctors working in cardiology and 75% in stroke departments had completed their mandatory training.
- There was low mandatory training compliance among nurses working in medicine at the hospital. The trust told us only respiratory medicine nurses were up to date with their mandatory training. Compliance levels reported for other specialities varied between 53% for

Medical care (including older people's care)

elderly medicine, 74% for acute medicine and 63% for oncology. Summary of attendances at statutory and mandatory training to June 2014 showed that all healthcare assistants working in gastroenterology had completed their mandatory training. However, compliance levels for specialist medicine, acute medicine, oncology, elderly medicine and cardiology was around 40%.

Assessing and responding to patient risk

- A number of risk assessments were completed shortly after patients' admission to ensure their needs were met. These included skin care, falls and the need for bed rails, manual handling and nutritional risk assessments.
- Staff knew how to escalate the case if there was a deteriorating patient. Doctors were available on call at all times if a patient required medical support. The NEWS system was used for early recognition and escalation of a deteriorating patient. We observed NEWS charts were appropriately completed.
- The Situation-Background-Assessment-Recommendation (SBAR) framework supported staff in conversations, especially critical ones, requiring a clinician's immediate attention and action to clarify what information should be communicated between members of the team.

Nursing staffing

- There were high vacancy rates among nursing staff. For June 2014, nursing vacancy rates on the wards were; stroke 22.92%, acute medicine 18.34%, elderly 7.97% and oncology 17.23%. The trust told us there were no vacant nursing posts in cardiology and respiratory medicine.
- There was a 20% vacancy rate for healthcare assistants in neurology but this related to a single 1.00 WTE post. There were no healthcare assistant vacancies in cardiology, elderly medicine and the stroke department.
- For June 2014, nursing staffing on the acute medicine wards had 3.07% of its operating WTE attributable to agency staff, for elderly medicine wards it was 0.82%, for neurology wards it was 1.25% and for specialist medicine wards it was 1.21%.
- For June 2014, nursing sickness absence rates on the stroke wards was 8.45% and 2.61%. For the oncology wards this was 1.63% and 5.78%.

Medical staffing

- There were high vacancy rates among elderly medicine consultants (20%) and the stroke department (15%). The stroke department was the only speciality with no training grade vacancies. The trust told us there were no vacant consultant posts in cardiology and acute medicine.
- Vacancy rates for trainee doctors were high in oncology (50%), cardiology (25%) and the infectious diseases department (20%).
- We observed mostly low use of locum doctors within all other medical specialities (between 0% and 2%).
- Sickness absence for all medical staff within the following specialties at Charing Cross Hospital in June 2014 were, diabetes 0%, endocrinology 0%, neurology 2.71%.

Major incident awareness and training

- There were site managers available to oversee operational issues, particularly out of hours and at weekends, and they were responsible for coordinating in the event of major incident.
- There was a site-specific major incident plan reviewed in December 2012. This contained 'action cards' to assist staff in taking control and coordinating actions in the event of major incident. Nurses and doctors were aware of the policy, or knew who to refer to, if there was a major incident on their ward.

Are medical care services effective?

Good



The hospital was the third best performing hospital in the country among the trusts taking part in the Sentinel Stroke National Audit Programme. Pathways used for the assessment and management of patients' medical conditions were informed by appropriate national guidance.

Patients were given information about pain and offered appropriate pain relief when needed. Patients' nutritional needs were assessed and monitored appropriately. Staff were competent and knowledgeable and there was good communication among staff involved in the care and treatment of patients. The multidisciplinary team worked well together and there were no delays in discharging patients at weekends.

Medical care (including older people's care)

Evidence-based care and treatment

- All clinical staff could access National Institute for Health and Care Excellence (NICE) guidelines online and policies made reference to relevant published guidance. Doctors and nurses told us they were encouraged to develop their clinical practice and participate in courses appropriate to their role, to ensure the care they were delivering was evidenced-based best practice.
- There was a process for reviewing clinical guidelines to ensure this reflected current practice and was informed by relevant national guidance.
- Regular meetings were held to update staff on current practices and new protocols, and also to discuss developments within the different specialities.

Pain relief

- Patients told us they were happy with how they were supported to manage their pain. They said they got pain relief when they wanted it and staff regularly checked whether they were comfortable.
- Staff used a pain assessment tool to support cognitively impaired older people and were able to refer to the trust's pain management policies and procedures.

Nutrition and hydration

- Patients' comments to us about the food included: "good and there were plenty of choices" and "choices were rather limited". They had access to adequate amounts of food and hot and cold drinks were freely available. Food and fluid charts were completed for patients identified as at risk of dehydration or malnutrition.
- We observed 'red trays' were in use, which alerted staff to patients who required support to eat. Meals were served during a protected meal time. Staff told us this was done to minimise other activities on the wards and to ensure adequate support was provided to patients.
- The hospital provided a range of meals from a seasonal menu which had been developed to meet the cultural, religious and dietary requirements of the patient population.

Patient outcomes

- The hospital was the third best performing hospital in the country among the trust taking part in the Sentinel Stroke National Audit Programme (SSNAP) in January to March 2014. This audit reviewed stroke services against evidence-based standards, and national and local benchmarks. The hospital was twelfth when compared

with other non-routine acute teams accordingly to the same audit. It was highlighted through the SSNAP audit that the hospital needed to make improvements in relation to accessibility to speech and language therapy, the number of patients who had multidisciplinary team involvement within 72 hours, and patient rehabilitation goals agreed within five days.

- The hospital participated in the national clinical audit of inpatient care for adults with ulcerative colitis (form of inflammatory bowel disease). The report for 2013 indicated the hospital scored better than average for the UK in four out of seven key indicators.
- The information from the Myocardial Ischaemia National Audit Project (MINAP) suggested that treatment provided to patients with a heart attack, (nSTEMI) was better than the England average. This was a national clinical audit of the management of heart attacks covering the period between April 2012 and March 2013.
- The hospital had performed better than the England average in the National Diabetes Inpatient Audit (NaDIA) completed in September 2013 in 11 out of 21 measures. The NaDIA indicated there was a significantly lower number of patients who were seen by the multidisciplinary foot care team (25%) when compared with 2012 results (100%) and fewer patients were happy with meals choices offered. In addition, the overall satisfaction level had been lower than in 2012.
- The hospital participated in the National Heart Failure Audit 2012/13 which collects data on patients with an unscheduled admission to hospital who were discharged with a primary diagnosis of heart failure. The hospital performed better than the England and Wales average in seven out of 11 indicators. This audit indicated that all patients had input from specialists as appropriate and in 97% of cases patients were diagnosed with the use of echocardiography. However, only 24% of patients were treated on specialist wards (50% was the England and Wales average) and fewer than expected were referred to the heart failure liaison service; and 67% of all patients were prescribed a beta blocker medication used to protect the heart from a second heart attack (the average for England and Wales was 82%).
- Hospital Standardised Mortality Ratio (HSMR) indicators were better than expected for the period October 2012 to September 2013 for both weekday and weekend stays.

Medical care (including older people's care)

- The trust was in the top 10 trusts in the country for being below the national average Summary Hospital-level Mortality Indicator (SHMI) rate.
- We observed, in elective cases, that there was better observed emergency readmissions (patients who return to hospital within 28 days post-discharge from hospital) than the expected 100. For gastroenterology it was 89 and neurology 84 in 2013/14.
- In other specialities, such as medical oncology, the ratio was worse than expected (143 compared to the expected 98).
- For non-elective treatments in neurology the readmission rate was much better (69) when compared with the England average (100). However, it was worse than expected in general medicine (107) and significantly worse for gastroenterology patients (138). Senior members of staff said this reflected the complexity of the patients' conditions treated at the hospital.
- Overall the hospital's readmission rate for all elective treatments (109) was slightly worse than expected (100). For non-elective treatments, the readmission rate was slightly better (96) than expected (100).

Competent staff

- There were specialist study days organised for all staff who spoke highly of the quality of the training provided. For example, there was a stroke study day organised for healthcare assistants. There were also 'theme of the week' discussions organised on some of the wards.
- Staff reported that they were able to discuss clinical issues at the handover and ward meetings.
- The trust had implemented a new staff personal development programme in 2014. We observed it was used across the hospital and most nursing staff had been appraised by their line manager in the past year. Staff reported they were generally happy with the process. They confirmed the process included their professional development and told us they were funded to attend courses and improve their clinical skills.
- Staff told us their induction to the unit had been very good and they felt well-supported.

Multidisciplinary working

- There were multidisciplinary teams allocated to each of the wards with weekly staff meetings taking place. We observed ward rounds where various specialists were involved to ensure that the delivery of care was appropriate and effective. For example, on Ward 6

North, the daily ward round was led by an oncology consultant and included trainee doctors, a member of the palliative care team and a specialist in pain management. There was also an occupational therapist, a physiotherapist, a discharge team leader and a social worker. Stroke patients were reviewed by a consultant stroke physician and a neurologist to optimise investigation and management.

- Patients received input from a dietician, speech and language therapist, tissue viability nurse, physiotherapist and occupational therapist. There was good pharmacy support on all wards with the pharmacist present on the acute medicine wards 8am–7pm. Doctors and nurses were complimentary about the support they received from the team.
- The hospital had a team called the older people's assessment and liaison team (OPAL). This was a consultant-led team available 24 hours which ensured older peoples' needs were specifically identified on admission.

Seven-day services

- Consultants and registrar doctors were not available at night but were available on call in the evening and at the weekend for all the medical wards. Junior doctors and nurses told us on-call consultants were quick to respond and they arrived on site within 30 minutes.
- Nurse staffing levels remained the same at weekends as they were during the week. They were adjusted during night-time to reflect the reduced level of activity.
- There were no delays in discharging patients at weekends. Pharmacy services were available out of hours to allow prompt discharge of patients.

Are medical care services caring?

Good



Medical services provided to patients at Charing Cross Hospital were caring. Staff displayed caring attitudes and spoke to patients in a dignified way. Patients told us doctors and nurses were friendly and they treated them with respect and compassion. Patients also told us they felt involved in decisions about their care and treatment.

Medical care (including older people's care)

Compassionate care

- Throughout our inspection we observed staff interacting positively and in a friendly manner with patients and families; both in person and in telephone conversations. Patients told us “nurses are attentive”, and they were “very patient”.
- The hospital's results from the NHS Friends and Family test for 2013/14 indicated nine wards out of 12 often scored better than the England average. Wards 9 North and 9 West were among the highest rated wards.
- Three wards that rated worse than the England average included Wards 8 South, 6 North and 8 West, which scored worse than the England average for more than seven of 12 months (April 2013 to March 2014).
- We observed low response rates for the Friends and Family Test on some of the wards (below 20%). The trust was working towards improving the response rate to 40% across the hospital by March 2015.
- The trust was rated among the worse 20% of all trusts participating in the National Cancer Patient Experience Survey 2012/13. The survey indicated that only 63% of participating patients were given written information about the type of cancer they had. Half of all participating patients were told about treatment side effects that could affect them in the future and 61% found it easy to contact a specialist nurse.

Patient understanding and involvement

- Patients were very knowledgeable about their conditions and treatments. They were involved in their treatment and well-supported by staff. One patient told us, “doctors were approachable” and staff always “explained things.” Another said, “I understand what they say, doctors are excellent and nursing staff are also very good”.
- Staff were attentive to patients' needs. We observed them speaking reassuringly to patients, explaining their treatment and seeking their consent.
- Patients' families told us they were kept informed about their relative's care.

Emotional support

- Patients told us they felt supported by staff if they needed emotional support.
- There were Macmillan nurses available to support patients undergoing treatment for cancer. Macmillan cancer information and support service was based at the hospital to offer emotional and practical support.

There was also a Maggie's cancer caring drop-in centre in close proximity to the hospital which provided free emotional and social support to people with cancer, their family and their friends.

- The stroke support group met on a monthly basis to provide an informal forum for all stroke survivors and patients with transient ischaemic attacks (mini strokes), their family, friends and carers. Among other support services available was a heart support group set up by former heart patients of Charing Cross Hospital. The group gave patients the chance to meet other patients to learn more about living with heart problems.
- Chaplaincy services were provided to patients and visitors of various faiths.
- The counselling team was based on the same floor as two oncology wards and support was easily available on patients' request. Staff told us they often initiated referral for counselling on patients' behalf after obtaining their consent.

Are medical care services responsive?

Requires improvement 

There were a number of hospital discharges taking place after 10pm and there was a long wait for a lift if patients were being transferred from one floor to another. There were limited day room facilities for patients and their visitors on some of the wards. Care plans for people living with dementia and diabetes were not fully implemented in the hospital.

However, the hospital took account of patients' views and feedback from patients' complaints was used to improve the service.

Service planning and delivery to meet the needs of local people

- The trust told us they undertook a review of services provided to oncology patients in response to the national Cancer Patient Experience Survey 2012/13. A senior nurse told us staff had received additional training in palliative care. A doctor said all cancer patient care pathways had been reviewed and transformed to ensure improved experience. The hospital also ensured an adequate staffing level was

Medical care (including older people's care)

maintained on oncology wards and additional permanent nursing staff were recruited. One oncology ward had been redecorated and another one was due to be refurbished in September 2014.

- Medical wards were located in a tower block where patients were transferred in a lift. We observed there was a long wait for a lift if patients wanted to transfer from one floor to another. The stroke ward was located on the ninth floor and doctors told us the transfer time added to the medical intervention response time.
- Visiting times were clearly indicated on all wards. Visitors who wanted to stay overnight could book an accommodation provided by the hospital which included a bathroom and a kitchenette.
- The wards we visited were spacious and well-designed. Some had been recently redecorated.
- Staff told us they had access to equipment and facilities for repairs and maintenance on all wards. This included pressure ulcer prevention equipment such as pressure redistribution mattresses or seat cushions.

Access and flow

- Patients had access to right care at the right time and the hospital managed patients' access and flow effectively. Conference calls were organised across three of the trust's hospitals to address any patient flow and bed capacity issues. These occurred three times a day.
- From June 2014 to August 2014, 58 patients were transferred to another ward out of hours (10pm – 7am), most of them being gastroenterology or medical oncology patients. In the same quarter we observed a number of patients discharged out of hours.
- Average length of stay for the hospital in 2013/14 was two days and this was shorter than the England average for elective cases of four days. Medical oncology and respiratory medicine patients' stays were in line with the England average. Neurology patients' stay was four days shorter than the England average of seven days.
- Nurses told us bed occupancy levels were high, but we observed good cooperation across the hospital and division to manage bed capacity issues.
- The majority of patients were admitted to the medical wards from the A&E or the clinical decision unit (CDU). Cardiology patients could be admitted via rapid access cardiology clinics, where patients with chest pain, suspected heart failure or arrhythmia were seen. Patients were often brought to the HASU by an ambulance. The HASU provided the initial investigation,

treatment and care immediately following a stroke. Patients spent an average of 72 hours in the HASU before being transferred to a 'step down' ward. Patients could be admitted to Lady Skinner Ward, where the medical, psychological and functional capabilities of older people were assessed, following referral from their GP or community services. They could also be referred through the older persons rapid access clinic (OPRAC) which was based at the hospital.

- The number of patients who were placed in other departments' wards due to the lack of beds (medical outliers) varied between 101 patients in March 2013 to 31 in June 2014. It was mostly oncology patients who were placed on non-specialist wards. Doctors and nurses told us they felt that all patients placed on other wards had received appropriate medical support coordinated by the consultant.
- On the day of inspection, there were 273 medical patients at the hospital. Most of them (126) had stayed for no longer than three days. There were 37 patients who had been admitted for more than 28 days, although the length of stay for most of the elderly medical patients varied between 11 and 27 days.
- Nurses told us that patient discharge was planned from the day of their admission and delays were rare. They told us the discharge procedure was effective, but occasional delays occurred where there was a problem with arranging nursing homes placements or when other non-acute care needed to be arranged. The discharge team and pharmacist were involved in patient discharges. However, there was no discharge lounge at the hospital. If patients were awaiting transport they were required to wait on the ward. Staff told us newly admitted patients were not affected by this as patients awaiting transport did not occupy a bed.

Meeting people's individual needs

- The hospital catered for the individual meal choices of patients, such as salt-free food, nourishment drinks and various cultural meals.
- Dementia specialist nurses worked across the trust sites and provided information and consultation to staff members who needed additional support relating to dementia care. However, we noted and our discussions with the dementia lead and other nursing staff/ healthcare assistants showed that care plans for people living with dementia were not fully implemented in medical services in the hospital.

Medical care (including older people's care)

- There were no 'insulin passports' or diabetes-specific care plans to let patients undergoing insulin therapy to be more active in their own treatment.
- The trust told us there was a 'zero tolerance policy' in relation to mixed-gender accommodation. No breaches in mixed-sex accommodation were reported for the hospital since April 2014.
- There was limited access to day activities or entertainment such as television or radio at patients' bedsides. Only some wards had day rooms and quiet rooms where patients could spend time with their relatives, but those rooms had no televisions, literature or radios. Patients on the Lady Skinner Ward whose living skills and mobility were assessed on the ward, had access to a day room and a greater level of activity than on other wards.
- Staff were aware of how to treat and support patients with mental health and learning disability needs. There was a clear admission and discharge pathway designed for people with a learning disability.
- Staff said they had good access to translation services and were able to communicate with patients who did not speak English.

Learning from complaints and concerns

- Nurses gave us examples of where the medical services had acted on comments made in formal complaints. Feedback from patients' complaints and action plans were discussed in ward meetings. Staff said they had not had many complaints but were aware how to respond and of the role of the Patient Advice and Liaison Service (PALS).
- We observed leaflets were available on all wards informing patients how to raise concerns and providing them with information on PALS. Information about how to complain was also available on the trust's website.

Are medical care services well-led?

Requires improvement 

It was not clear what actions, if any the senior management were taking to address the high vacancy and absence rates among some groups of nursing staff. Whilst staff

participated in the NHS Staff Survey and the national training survey, organised for trainee doctors, there was not detailed information on how the medical services performed.

There were clear governance, risk management and quality measurement processes on medical wards. The senior members of staff were visible and staff told us they provided good leadership. There were identified clinical leads in medical specialities. The service engaged with patients and staff and their views informed service planning and delivery.

Vision and strategy for this service

- Staff working at the hospital were consulted and encouraged to participate in strategy development. They were aware of the new clinical strategy which set out how the trust wanted to develop services to meet the changing health needs of the local population.
- There were long-term strategies to ensure quality improvement and to define the aims for the trust and individual divisions and departments. For example, there was a three-year nursing and midwifery strategy displayed in the nurses' office which supported the delivery of care and set objectives and priorities. However, nurses could not tell us what those objectives were.
- The trust was in the process of developing a four-year dementia strategy which set priorities and actions for meeting the needs of the ageing population. The dementia coordinator was involved with development and implementation of this strategy.
- Senior nurses used their 'back to the floor' sessions to assess wards against a number of criteria, which were important to patients. They checked if the wards were welcoming, caring, safe, calm and organised. These sessions also supported the 'patient and carer experience strategy'.

Governance, risk management and quality measurement

- We noted above that there were high vacancy and absence rates among nursing staff in some departments. It was not clear what the senior management was doing to address these and therefore posed a potential risk to the safety and welfare of patients.
- There were clear governance, risk management and quality measurement processes on medical wards.

Medical care (including older people's care)

There were regular senior nurses meetings as well as ward meetings where risk and governance issues were discussed. Staff participated in local audits and were encouraged to take on additional responsibilities in accordance with their interests.

- Risk registers were not kept locally but at divisional level. There were regular medicine division safety committee meetings attended by the managers from the trust's three main hospital sites and representatives of different specialities. Risks related to different specialities were discussed at this meeting and outcomes shared with the trust's quality and safety committee.
- There were other medical specialities' quality and safety meetings held and outcomes from those meetings were shared with the medicine division safety committee.

Leadership of service

- There were identified lead professionals in most areas, including a ward manager on all wards who provided local leadership, an identified clinical lead for each of the medical specialities, and a divisional lead.
- The senior nurses and matron were visible, supporting staff, overseeing their training and appraisals. They felt involved in the management decisions that affected their wards and were consulted on issues regarding service delivery.
- Junior doctors said they had systems to support them, particularly out of hours.

Culture within the service

- Staff told us they were happy working at the hospital and felt they contributed to creating a positive work environment. We observed mostly good communication between staff members.
- Staff participated in the NHS Staff Survey and the national training survey, organised for trainee doctors. There was an action plan developed for the medicine division in response to the surveys to address the issues highlighted.







Public and staff engagement

- The medical wards had been inspected by members of the patient group in 2014. This group was made up of patients and people interested in improving the patient experience. Findings of these patient-led assessments of the care environment (known as PLACE) were shared with the Trust Board.
- Patients were able to provide feedback by responding to the NHS Friends and Family Test or by using the 'I track' electronic survey devices which were used to gather patient feedback. The feedback provided through the Friends and Family Test was positive overall. Feedback received was communicated with the individual teams and patients' views were taken into account when objectives were set for the division and individual wards.
- The hospital encouraged patients to become involved with the charity Friends of Charing Cross Hospital which raised funds for projects to provide patient comforts and medical equipment.

Innovation, improvement and sustainability

- The trust had developed a five-year clinical strategy designed to improve clinical outcomes and the patient experience, to help people stay as healthy as possible and to increase access to the most effective specialist care. This also informed the estates management strategy and the plan for major redevelopment of the hospital site. The trust was working with the local commissioners to develop an engagement programme to involve staff and local communities in shaping those plans.
- Charing Cross Hospital was home to a sleep centre which was a purpose-built, diagnostic sleep environment with six dedicated sleep rooms. The centre treated a range of sleep disorders including obstructive sleep apnoea syndrome, periodic limb movement disorder, circadian rhythm disturbances and narcolepsy.

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

Information about the service

Charing Cross Hospital provides a range of surgical services, including ear, nose and throat (ENT), breast, urology, head and neck, elective orthopaedics, plastic surgery and neurosurgery. Surgical procedures were divided into 45% day case procedures, 33% elective and 22% emergency cases.

There were 116 beds in the designated surgical wards. Day surgery was mainly undertaken in the Riverside Wing, which contained 26 beds. The 16-bed transgender specialist unit in Marjorie Warren Ward had been recently relocated to the Riverside Wing and was closed at the time of our inspection. Ward 7 South was a 25-bed ward for elective orthopaedics, Ward 10 South contained 23 beds and specialised in head and neck, plastic surgery and ENT surgery. Ward 7 North was a general surgery ward with 26 beds. There were elective and emergency theatres at Charing Cross Hospital, with 10 main theatres and three day care theatres.

We spoke with nine patients, observed care and treatment and looked at eight care records. We also spoke with 29 staff members at different grades, including allied healthcare professionals, nurses, doctors, consultants, ward managers, matrons and members of the senior management team. 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 hospital had not taken sufficient steps to ensure the 'Five steps to safer surgery' checklist was embedded in practice, despite two 'Never Events' occurring elsewhere in the trust in the preceding 18 months.

While there was evidence of good outcomes for patients who underwent surgery, the hospital was not sufficiently responsive to patients' needs. The trust did provide us with evidence of a plan to reduce the backlog of patients waiting for elective surgery to deal with patients who had experienced long waits for their surgical interventions.

Surgical wards had low numbers of nursing vacancies; they regularly reviewed the skills mix and used a low volume of agency staff. Patients spoke positively about their care and treatment at the hospital. They told us staff were caring, compassionate and professional.

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Are surgery services safe?

Requires improvement



Charing Cross Hospital had not taken sufficient steps to ensure the 'Five steps to safer surgery' checklist was embedded in practice. While there had been no reported incidents at this site, a recent serious incident of a retained swab had occurred at St Mary's Hospital which involved incomplete or ineffective use of the World Health Organization (WHO) Surgical Safety Checklist as had been reported. Furthermore, two 'Never Events' had been reported at two other hospitals within the trust in the preceding 18 months. Therefore, we were not assured that surgical procedures were sufficiently safe.

Ward areas were well-staffed and daily consultant-led care was also usual. Staffing levels and skills mix were maintained and the use of acuity tools was embedded in practice. However, we were not assured that there were sufficient proactive initiatives to reduce the high numbers of falls.

Incidents

- There was a process for investigating 'Never Events' (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) and patient safety incidents, including serious incidents requiring investigation. The hospital reported one 'Never Event' at Charing Cross Hospital relating to wrong site surgery involving removal of bunions. Despite the fact the patient came to no harm as a result of this event, the event had been thoroughly investigated and an action plan produced from lessons learnt. Managers told us the action plan had been implemented and associated learning had been shared with relevant hospital staff.
- The theatre and surgical ward staff we spoke with told us they all had access to the electronic incident reporting system, and were clear about incidents that needed to be raised.
- Staff told us learning from incidents took place through weekly and monthly multidisciplinary meetings and bi-monthly audit meetings. In addition, staff on the surgical wards were given feedback about reported incidents in weekly briefings, as well as via regular newsletters. Staff were able to describe recent incidents, including those that occurred at other hospital locations within the trust, for which staff described how learning was shared to aid improvement.
- Divisional managers told us mandatory training for all staff at senior manager grade and above included a module in investigation of incidents and complaints. However, some staff we spoke with at this level were unaware of this training.
- We were also told most trust staff had received training in having difficult conversations, including discussing incidents.
- Data provided by the trust showed a better-than-national-average reporting rate of 'no harm' incidents. Staff also told us they felt confident in the trust's reporting systems, and these elements demonstrated that incident reporting systems worked in practice.
- There were a number of serious incidents reported within the surgical division. Between 1 July 2013 and 30 June 2014, 35 serious incidents were reported trust-wide, 18 of which were attributable to Charing Cross Hospital. We were told this information was collected and reported on a trust-wide basis and therefore could not identify where in the surgical division these incidents had occurred.
- Data provided by the trust showed that between Jan13 – July14, a total of 17 pressure ulcers at grades two or above were recorded for surgery. Staff told us they risk-assessed patients at risk of developing pressure ulcers, reported incidents when pressure ulcers were detected and were supported by the tissue viability team. It was not clear that the actions from investigations of reported incidents were embedded. Although all serious incidents were investigated, we were not assured that there were sufficient proactive initiatives to reduce incidents such as the numbers of falls. Trials of falls prevention equipment such as alarm mats were being discussed, but had yet to be put into practice.
- Mortality and morbidity meetings were varied in quality and frequency. Meetings took place at a speciality level, with reporting to the quality and safety committee by exception. We found some specialties, such as orthopaedics, reviewed mortality and morbidity bi-monthly at the end of the surgeon's audit meetings. We were told by clinical staff that some actions and lessons arose from these meetings, but as there were no

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action plans produced from the meetings, we were unable to determine who was accountable for any actions or learning, or what improvements had occurred as a result.

Safety Thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and harm-free care. This includes information about all new harms, falls with harm, new venous thromboembolism (VTE or blood clots), catheter use with urinary tract infections and new pressure ulcers. VTE risk assessments were being completed and the trust had measured the compliance rate with these assessments.
- Safety Thermometer information was clearly displayed in prominent places of the surgical ward areas during our inspection. On all surgical ward areas, the trust's performance was better than the England average. Results from the harm-free care report for July 2014 for the surgery, cancer and clinical haematology division, covering all surgical ward areas at Charing Cross Hospital, showed overall harm-free care scores were close to or over the national benchmark of 95%. Across all three hospital sites in the trust, the surgical division was 96% harm-free overall. The investigative sciences and clinical support division, which includes operating theatres and anaesthetics at Charing Cross Hospital, was 100% harm-free overall. Lead nurses provided submission of nurse-sensitive quality indicators to the trust database, which were reviewed by heads of service. We were told these were exception reported at lead nurse meetings. Most surgical ward areas were compliant with these indicators at time of our inspection.
- The lead nurse told us spot checks were undertaken on twilight shifts and staff confirmed these took place, but were not recorded.

Cleanliness, infection control and hygiene

- We found local and national guidance for infection control was being followed and implemented at the hospital. The trust infection rates for *Clostridium difficile* (*C. difficile*) and methicillin-resistant staphylococcus aureus (MRSA) were slightly worse than the average range for England, even taking into account the trust size and the national level of infection. All cases were

investigated and senior managers told us most actions to address the root causes identified following investigations of each case of *C. difficile* or MRSA had been implemented.

- Following any surgery performed on a patient with a known infection, the theatre was deep cleaned to reduce the risk of cross-infection. These patients were placed at the end of a surgical list, if possible, to minimise the risk of infection.
- Data gathered prior to the inspection showed there was a low number of catheter-acquired urinary tract infections.
- During our observations, and when speaking with patients in surgical ward areas, we confirmed that all areas were clean and tidy. Monthly cleaning audit results showed compliance across all three hospital locations was over 90% across all ward areas in the preceding 12 months.
- Hand hygiene compliance was audited monthly by staff in each surgical ward area. Scores were routinely 95% and above across all areas, and across the division it was 97.7%.
- The theatre complex at Charing Cross Hospital was clean and equipment stored to enable effective cleaning. There was weekly washing of the walls, and the equipment and the environment were observed to be clean.
- Theatres at Charing Cross Hospital had undergone a programme of renovation to improve ventilation. The theatres we inspected were clean, safe and well-maintained. Daily and weekly cleaning checklists were displayed in each area and these were complete and up to date. Monthly cleaning audit results showed compliance was over 90% in the preceding 12 months.
- Staff regularly washed their hands and used hand gel between attending to patients. They followed 'bare below the elbow' guidance and were aware of current infection prevention and control guidelines. Gowning procedures were adhered to in the theatre areas, and in ward areas staff wore personal protective equipment, such as gloves and aprons, while delivering care.
- The dedicated infection control team for the trust included a senior nurse who specialised in reducing the incidence of surgical site infections. We were not provided with specific details of the rate of surgical site infections at Charing Cross Hospital.
- Patients we spoke with told us, "It's exceptionally clean here".

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Environment and equipment

- The recovery area was a clean. The theatre department had started using a barcode tracking and tracing system for surgical equipment to accurately ensure specific surgical sets. We saw this working in practice at Charing Cross Hospital.
- We were told by staff that there were delays in requesting equipment on some surgical wards and in theatres which sometimes led to delays to surgery. Equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule.
- Staff in each theatre team were responsible for checking equipment on a daily basis and any equipment failures or issues were logged as incidents.
- We checked resuscitation equipment in surgical ward areas and in theatres and found emergency drug packs and the defibrillator were checked daily and were ready for use.
- Staff told us that micro instruments, used in surgical specialties such as plastics, were regularly damaged. Some theatre staff we spoke with at Charing Cross Hospital told us there were regular delays in responses to requests to the estates management department when equipment or structural repair was required.
- Staff on some surgical wards at Charing Cross Hospital spoke of difficulties accessing air mattresses to enhance pressure area care. Senior staff told us this may have been because the supply was managed by an external company.
- Resuscitation trolleys on all surgical ward areas were in working order, checked daily and staff we spoke with demonstrated how they would be used in an emergency situation.

Medicines

- Drugs were stored safely on most surgical ward areas; on Ward 7 South, we noted that the medicines room was locked and accessible via a key code. Although the medicines fridge inside the room was unlocked, this was in line with the trust's policy as it was inside a locked room. Fridge temperatures were checked daily to ensure medicines were stored appropriately and safely.
- On the wards and in theatres, medicines were stored correctly in cupboards. Medicines were only prepared when needed, with the exception of medicines for use in emergency cases, which was in line with trust protocol.

- All staff received a competency-based assessment before administering medication. We were told that, when a drug error was identified, the staff involved received another drug competency assessment to ensure safety.
- Controlled drugs were checked daily and at night in line with trust guidelines.
- Pharmacists were allocated to each ward area to review medicines charts as well as provide patient-specific advice and support timely provision of discharge medication.
- Processes to check progress with ordering and dispensing take-home medicines were carried out on surgical wards by nursing staff to expedite patient discharge.

Records

- Patients had their care needs risk-assessed on admission and when their needs changed. These were recorded in their records in all the clinical areas we visited. Patient records showed that staff carried out appropriate checks for consent and medical history prior to starting a procedure.
- Staff on surgical wards described ongoing difficulties they faced since the introduction of a new electronic patient administration system in April 2014. Staff spoke of difficulties with patient information being sent to wrong patients, difficulties in tracking notes and locating test results and letters. The trust had recognised this as a trust-wide issue and implemented a series of actions. Staff told us they had recognised this was slowly improving.
- Ward matrons we spoke with told us they walked around the wards to review care, including regular reviews of pressure area documentation. We were not provided with evidence of these reviews.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- In the patient records we reviewed we found informed consent was sought and recorded appropriately and correctly. We saw documented evidence of preoperative risk assessment which included establishing informed consent by speaking to preoperative and postoperative patients about their understanding of their surgery.
- Staff demonstrated knowledge of the Mental Capacity Act 2005 and the implications of this in protecting patients' rights. Through a review of patient records, we saw staff had assessed patients' capacity to make

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decisions, and when patients lacked capacity, staff sought advice from professionals and others as appropriate so a decision could be made in the patient's best interest.

- Staff had the appropriate skills and knowledge to seek consent from patients or their representatives. Staff had received mandatory training in consent and had access to a simple device, accessible via a mobile phone app, for training about the Act and its associated deprivation of liberty safeguards. However, staff told us that, while this was helpful awareness training, more training in dealing with specific cases would be beneficial.
- An annual consent documentation audit against the trust consent policy was undertaken. Results in October 2013 showed improvements in documentation including best-interest decisions. However, some areas had dropped below the standard, including documenting of consent for tissue retention and dating of consent by the patient.

Safeguarding

- Systems were in place for staff to report on safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect. This process was supported by staff training and all of the ward staff we spoke with about safeguarding had undertaken training in safeguarding adults and children at level 3.

Mandatory training

- We looked at staff mandatory training records on the wards we visited and found between 79% to 86% of staff in surgical ward areas at Charing Cross Hospital had received mandatory training at the time of our inspection. However, ward matrons told us this data was not always accurate, and felt that rates were higher than stated. They told us this was because online training modules were often not recorded, even if staff had completed them. We were informed that the trust had a robust action plan to ensure all staff received their mandatory training during the current financial year. Ward matrons told us they were now asking staff to demonstrate completion of each module in person.
- There was a worse-than-average compliance rate with mandatory training among consultant medical staff. Some consultants had not completed any mandatory training and we were not made aware of what was being done to address this low rate of compliance.

- In theatres, 70% of nursing staff, operating department practitioners and healthcare assistants had completed their mandatory training as of July 2014.

Assessing and responding to patient risk

- The surgical wards used a recognised alert tool, the National Early Warning Score (NEWS) system, for standardising the assessment of acute-illness severity. We found clear directions for escalation and staff were aware of the appropriate action to be taken if patients scored higher than expected. We looked at completed charts and saw staff had escalated correctly, and repeat observations were taken within necessary timeframes. A pro forma highlighting patient NEWS was used during daily nursing handovers on surgical wards at Charing Cross Hospital.
- Staff described their roles and identified the necessary steps to take in the event of a clinical emergency. They were able to identify the location of emergency equipment and describe the steps outlined in the hospital's emergency policy.
- We were told the nursing leads attended to their allocated ward areas at 7am every day to ensure unwell patients had been escalated proactively to consultants. Staff spoke about using clear communication, prompted by a recognised tool called the Situation-Background-Assessment-Recommendation (SBAR) technique.
- Patients, who were pre-assessed by the centralised specialist team, were risk-assessed in line with national guidance on preoperative assessment. We observed the checklist in use during our inspection and the three assessments we reviewed were completed appropriately. We could not be assured of the approach to risk management used by the specialties who managed their own preoperative assessment processes.

Use of the 'Five steps to safer surgery'

- We observed two theatre teams undertaking the 'Five steps to safer surgery' procedures, based on the WHO checklist. Theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'Five steps to safer surgery' procedures.
- The trust had started to carry out WHO checklist audits in April 2014, including swab counts. Two secret-shopper style audits were undertaken against compliance with the WHO surgical safety checklist. The staff we spoke with confirmed there were

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“observational” audits to verify staff adherence to the ‘Five steps to safer surgery’ procedures. These highlighted that ‘known allergy’ and ‘siting markings’ had a low compliance rate. Results showed 60% compliance with ‘briefing’ in June and 65% in July, while there was 0% compliance with the ‘debrief’ section. This had been identified on the division’s risk register, which stated that the July 2014 audit showed improvement in some areas on the WHO audit, but that debriefing was not occurring regularly enough. The August 2014 audit reviewed at the quality meeting demonstrated improvements in most areas.

- Swab count audits had been undertaken monthly since June 2013 on about 20 cases per month across all three hospital sites in the trust. Continued low compliance with handling, labelling of swabs, ‘pause for the gauze’ (the surgeon stopping while the first cavity count of swabs was done) and consistency of people counting the swabs had not been addressed.
- Overall, the risk of unsafe surgery was not sufficiently mitigated. Although compliance with the ‘five steps’ was escalated to the divisional risk register, actions stated that audits had mitigated the risk. The actions did not reveal there was a very low sample size or that cases reviewed did not highlight the very recent introduction of the ‘five steps’ checklist. There was, therefore, a false assurance for surgical safety.

Nursing staffing

- Surgical wards used an Association of UK University Hospitals approved adult dependency acuity tool to assess the needs for the number of staff on the surgical wards. The wards completed this assessment every six months. Nursing-sensitive indicators of quality, including bed occupancy and level of care, and wider measures such as number of incidents, drug errors and complaints, formed part of the assessment. Skills mix was reviewed on the basis of the results and an increase in staffing numbers could be requested based on the results of the assessment.
- We found that surgical wards were appropriately and safely staffed throughout this inspection. However, data provided by the trust for Charing Cross Hospital contradicted our findings during the inspection as it had suggested worse-than-average vacancy rates and use of agency staff.

- Data showed there was a higher-than-average use of agency staff on surgical wards at an average of 0.83%. Ward matrons we spoke with stated that recruitment drives for nursing staff across the trust had started to reduce reliance on agency staff.
- In theatres, July 2014 data showed there was an establishment of 139.63 for nursing staff, operating department practitioners and healthcare assistants. We were told there was a higher agency usage for operating department practitioners. We were told senior managers discussed bank (overtime) and agency use weekly and the number of vacancies in scrub and recovery nurses was reducing, though anaesthetic support remained difficult to recruit.
- Rosters showed that staff were rotated trust-wide. To maintain appropriate skills mix, staff were usually rotated within specialties in the same division and had to meet certain competencies. We found that the skills mix in the surgical division met the Royal College of Nursing recommendation of at least 65% trained nurses to 35% healthcare assistants.
- Nurses in charge, known as ward matrons, were supernumerary and in line with Royal College of Nursing guidelines were therefore not assigned patients to care for when on duty.
- The nursing staff sickness absence rate in surgery was stable at around 7.6%, which was worse when compared to the national average. Senior nursing staff told us these rates were monitored on a monthly basis but did not confirm whether underlying causes were reviewed.
- Exit interviews were regularly reviewed to monitor feedback from staff. Ward matrons we spoke with told us there were no trends identified from exit interviews as most staff went on to promotions.
- Ward matrons supported requests for healthcare assistants or extra staff to provide one-to-one care to ensure patients’ needs were appropriately met.
- Some staff told us they felt they needed more nursing staff at night. However, this was not confirmed by the most recent nursing acuity audit which showed that night staffing levels were appropriate to meet patients’ needs.
- Senior nurses attended ward rounds and held regular liaisons with the outreach team.

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- A nursing and midwifery staffing escalation guide called Care 123 was available to help staff calculate staffing numbers and see if it was sufficient to deliver safe patient care.

Surgical staffing

- There was a 24-hour, consultant-led care model across most surgical specialties at Charing Cross Hospital. The surgical specialties operated a 'consultant of the week' model, though ENT and plastic surgery had yet to use this model. Surgical handovers were carried out twice daily.
- As of June 2014, trust-provided data showed there was an average vacancy rate of 7% middle grade doctors at Charing Cross Hospital. The rotas we viewed showed vacancies that registrar grade positions were being covered by locums, which the trust management told us was in line with the national average.
- Some ward staff told us completion of discharge summaries was a problem due to a shortage of medical staff.
- The rotas confirmed registrar-level doctors provided night-time cover for theatres and surgical wards.
- Staff told us registrar-grade anaesthetists often led theatre lists at Charing Cross Hospital, rather than consultants, which they said had an overall negative effect on the prioritisation of patients.

Major incident awareness and training

- There was a documented major incident plan which listed key risks that could affect the provision of care and treatment. We were told there was no specific policy for theatres and that staff followed trust guidelines.
- There were clear instructions for staff to follow in the event of a fire or other major incident. Staff were aware of the plans and described the appropriate action they would take. We were told there was no specific training for staff but surgical ward staff were aware of the policy.

Are surgery services effective?

Good



The outcomes for patients who had undergone elective surgery, urology and neurosurgery were better than the England average. The trust took part in national and local clinical audits and staff used care pathways effectively. Pain

relief was well-managed and the nutritional needs of patients were catered for. Staff were competent to carry out their roles and worked well within multidisciplinary teams. While we saw that many procedures and treatments within surgical services were reviewed against national clinical guidelines, the trust could not demonstrate the extent to which this was the case at Charing Cross Hospital.

Evidence-based care and treatment

- Charing Cross Hospital participated in national audits. This included audits knee and hip joint operations, oesophagogastric cancer and nephrectomy (surgical removal of a kidney) outcomes.
- National Institute for Health and Care Excellence (NICE) guidelines were managed corporately with a clinical lead assigned to each guideline, whereas national and local audits were managed by the divisions. Some specialties had audited their practice against NICE guidance. For example, anaesthetists demonstrated compliance with NICE guidance on temperature management during operations (NICE guidelines CG65).

Pain relief

- The trust employed a specialist pain team who provided direct support to surgical wards and undertook pain reviews, supported by the outreach team and on-call anaesthetists.
- We observed patients alerting nursing staff to their increased pain levels and saw their pain was addressed in a timely manner. Staff we spoke with told us they had access to the dedicated pain team on a daily basis.
- The pain team worked to evidence-based protocols, and had developed local guidelines for patient-controlled analgesia for postoperative and acute pain.
- In April 2014, nurses in the pain service conducted an audit to assess how pain was managed for patients not normally seen by the pain service, in medical and surgical areas across the trust's hospital locations. The audit reported a reduction in the number of patients reporting severe pain.
- The pain team lead was undertaking long-term research, reviewing prevention of chronic pain after thoracic surgery.
- A local audit of pain in April 2014 associated with epidurals concluded that a higher-than-expected number of patients experienced pain when moving and

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coughing with an epidural infusion. Recommendations to improve practice were identified, such as training for ward-based staff, and we were told this area would be re-audited in 2015.

Nutrition and hydration

- Patient records included an assessment of patients' nutritional requirements.
- Patients who were able to eat and drink normally told us they were given a choice of food and drink.
- Where patients had a poor nutritional intake, they were risk-assessed and fluid and nutrition charts

Implemented to ensure they received adequate food and drink. Where necessary, a dietician assessment was undertaken and specific interventions recommended.

- A local audit of emergency procedures by the anaesthetic department carried out in 2013 on a sample of 25 patients showed patients were waiting for significant periods of time post-admission for surgery before being offered a drink or intravenous fluids. In a few cases, the audits showed some patients waited up to 11 hours for fluids and 19 hours for food, which meant they were unnecessarily fasting for a prolonged period. The senior management team stressed that this was not representative of the number of patients who received emergency treatment at Charing Cross Hospital and that actions were being taken to improve the patient experience. We were told that the audit would be repeated by December 2014.

Patient outcomes

- Performance in some national audits demonstrated that outcomes for patients were within or better than the England average, particularly for major trauma and vascular surgery.
- The Hospital Standardised Mortality Ratio (HSMR), which compares the expected rate of death in a hospital with the actual rate of death, showed Charing Cross Hospital was statistically significantly low and better than expected.
- National bowel cancer audits outcome data showed the trust performed better than the England average, and was within the top 5% in the country.
- Upper gastrointestinal cancers were entered into the national audit and peer reviews, and results showed outcomes were better than the England average and among the best in the country.

- Senior staff told us they were now 100% compliant with outcomes from the London Cancer Alliance. In response to the London Cancer Alliance urology outcomes audit in 2013, the pathway for patients with a suspected prostate cancer before surgery was reviewed and improved.
- National Joint Registry audit data for 2013 showed Charing Cross Hospital performed better than the national average for all measures.
- British Association of Urological Surgeons' nephrectomy outcome data showed patient outcomes at Charing Cross Hospital were better than the England average.
- Performance against the Breast Cancer Quality Standard was monitored and Charing Cross Hospital were 90% compliant.
- Audits of nursing-sensitive quality indicators were undertaken for each surgical ward on a monthly basis, and these results were reported on the divisional quality scorecard.
- There was a trust-wide lead for delivering the enhanced recovery programme. Surgical ward staff told us all patients were considered for the enhanced recovery programme if suitable. However, the trust was unable to tell us how many patients were on this programme.

Competent staff

- Junior doctors we spoke with told us they were not asked to perform procedures unsupervised that they felt less than competent to do.
- The appraisal process was related to the trust's values and also tied to incremental salary increases.
- The trust funded a number of leadership programmes for staff, though we were not provided with detailed information to be able to identify how many staff within the surgical areas and in theatres had undertaken these programmes.
- Non-medical staff told us they received regular one-to-one supervision with their manager, while junior nursing staff also received regular feedback from an assigned mentor.
- Ward matrons monitored staff compliance with the trust's mandatory training programme. Rates were slightly lower than the trust expected standard of 90%, but we were told this was hard to monitor as some training modules were face-to-face and others were e-learning. Some ward matrons had to watch staff members completing these modules to provide evidence of completion.

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- A number of staff had attended relevant specialist courses and masters programmes.
- All theatre nursing staff and operating department practitioners were expected to complete a theatre orientation and perioperative handbook. Records were not available to confirm the proportion of staff that had attended this training.
- Healthcare assistants in theatres underwent a specific competency programme within the first 12 months of their role. The programme had been developed by the clinical skills educator for healthcare assistants at Charing Cross Hospital. Records were not available to confirm the proportion of staff that had attended this training.
- Staff told us they were regularly provided with opportunities for further study and training courses, and were able to attend.
- Ward nursing staff had regular support from education practice nurses and new nursing staff were supervised by senior nurses.
- Anaesthetic outcomes were being monitored against the Royal College of Anaesthetists guidelines and results were available by consultant grade. These were being used to inform the individual's appraisal and revalidation.

Multidisciplinary working

- Trainee doctors, nurses, physiotherapists and pharmacists told us they were well supported. Allied healthcare professionals worked well with ward-based staff to support patients' recovery and timely, safe discharge following surgery.
- Multidisciplinary team meetings were well-established to support the planning and delivery of patient-centred care. Daily meetings, involving the nursing staff, therapists, medical staff as well as social workers and safeguarding leads, took place when required. They ensured the patients' needs were fully explored and, where necessary, actions put into place to ensure their needs were met.
- Staff spoke of good support from the tissue viability team.
- On Ward 10 South, some patients having major surgery were looked after by a multidisciplinary team which included occupational therapists and physiotherapists, who were assigned to ward areas.

- Complex liaison discharge officers worked with staff and social workers to develop care packages for vulnerable patients.

Seven-day services

- We were told by the consultants that they undertook ward rounds seven days a week and on weekends they reviewed only new patients. The consultants were on site from 8am–5pm Monday to Friday and an on-call system operated out of hours and at weekends.
- Occupational therapy, speech and language therapy and dietetics were available 8am–5pm Monday to Friday.
- Staff told us out-of-hours imaging and pharmacy support was available when required. The imaging directorate was available Monday–Friday, 9am–5pm, with extended hours and weekends for magnetic resonance imaging (MRI), ultrasound and x-rays. Out-of-hours emergency services ran seven days per week and offered ad hoc sessions to address particular backlogs or peaks in demand.

Are surgery services caring?

Good



Staff in the surgical services were caring. We found feedback overall was positive from patients and their relatives during our inspection. NHS Friends and Family Test scores were better than the national average for almost all surgical wards. Staff interacted well and did their best to make patients comfortable.

Compassionate care

- The Friends and Family Test results were better than the national average for trust level at Charing Cross Hospital. Surgical ward matrons we spoke with had received an analysis of the responses and told us they were not aware of any trends.
- Patients and relatives were complimentary about the nursing and medical teams and the care they delivered. One patient said, "I cannot see a fault with the care". Patients were positive about the care received and told us, "Nothing is too much trouble here". One patient commented that staff provided clear explanations in preoperative assessment in a caring way, and said, "They have told me everything I need to know".

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- Throughout our inspection we saw staff providing caring and compassionate care to patients.
- Patients could be transferred to side rooms to provide privacy and to respect their dignity, though staff told us the rooms were often occupied which meant they were not always available when needed.

Patient understanding and involvement

- On admission, patients were allocated a named nurse to ensure continuity of care.
- We observed positive interactions between staff, patients and their relatives when seeking verbal consent. The patients we spoke with confirmed their consent had been sought prior to care and treatment being delivered.
- Patients and their families were involved in, and were central to, decision-making about their care and support. They had been given the opportunity to speak with their consultant.
- We found that relatives and/or the patient's representatives were also consulted in discussions about the discharge planning process.
- Patients' main carers were given the option of having an 'I am a carer' card to identify them to staff to allow visits to their loved ones outside of visiting hours.

Emotional support

- Staff understood the importance of providing patients with emotional support. We observed positive interactions between staff and patients and saw staff providing reassurance and comfort to people who were anxious or worried.

Are surgery services responsive?

Requires improvement 

Surgical services were not responsive to people's needs. The surgical department had a significant backlog of patients who were awaiting elective surgery; however the trust did provide us with overarching plans to reduce the backlog.

The arrangements in theatres were satisfactory; the surgical admissions lounge provided a suitable environment in terms of the patient experience with

respect to patient comfort, dignity and confidentiality. However, the clinical impact of cancellations and delays in surgery were not monitored in a consistent and robust way.

There was insufficient capacity to ensure patients admitted to the surgical services could be seen promptly and receive the right level of care. Bed occupancy was worse than the England national average. To meet the requirements of the North West London 'Shaping a Healthier Future' strategy and the trust's clinical strategy, bed numbers had reduced in some specialties. Staff told us patients were frequently cared for in inappropriate areas, such as in theatre overnight.

Service planning and delivery to meet the needs of local people

- There was 24-hour cover for emergency operations. All theatres were available over the weekend and overnight for emergency surgery.
- Staff told us patients sometimes experienced long delays in the recovery area after their surgery due to a lack of beds on the wards.
- Data showed the trust had a higher number of operation cancellations compared to the national average. We were not made aware of steps to address this.

Access and flow

- Referral to treatment times had varied over the last year and were close to the national average of 18 weeks. Operational standards were that 90% of admitted patients should start consultant-led treatment within 18 weeks of referral. Data showed that Charing Cross hospital was meeting, or close to meeting, the standard for neurosurgery, urology, oral surgery and plastic surgery.
- Theatre utilisation averaged 75% at Charing Cross Hospital, below the trust's target of 85%, though we were not provided with an explanation for this.
- We were not provided with bed occupancy rates that were specific to surgical wards at the hospital in the preceding 12 months. However, staff told us there were daily difficulties in identifying an appropriate bed for patients.
- The average length of stay for elective and non-elective procedures was close to the national average.
- We were told that many patients were commenced on an enhanced recovery programme from

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pre-assessment. Enhanced recovery programmes were in place for lower gastrointestinal surgery and hip and knee replacement orthopaedics, and were being developed for upper gastrointestinal surgery. This work was supported by an enhanced recovery nurse specialist. Senior managers told us the impact of these pathways was not being monitored across all areas.

- There were high rates of non-attendance for patients being admitted for surgery. We were told that patients were called shortly prior to their date of surgery to remind them, but this initiative to reduce non-attendances had only started in late August 2014 and therefore we were unable to assess its impact at the time of our inspection.
- Cancellation rates for surgical procedures were worse than the national average, averaging 20% at Charing Cross Hospital. Staff we spoke with told us cancellations were infrequent in day surgery at the hospital. We were not made aware of the actions being taken to address this higher-than-average rate.
- The trust reported that more than 180 patients were being cared for in non-surgical ward areas due to lack of bed availability in the preceding 12 months. We could not be assured that staff on these areas had the appropriate skills and competencies to provide care to surgical patients.
- Delays in transferring patients back to the wards from recovery were an identified risk and were documented on the divisional and trust's risk register.
- Pre-assessment had been identified by the divisional management team as an area of weakness. To address this issue, preoperative assessment was being gradually centralised to reduce the number of patients who did not attend or cancelled. Around 40% of preoperative assessments were undertaken at divisional level, whereas others were undertaken at specialty level. Pre-assessment was recognised as a risk by the trust as contributing to the high rates of patients who did not attend, and the higher-than-average referral to treatment times.
- The increase in the backlog of patients who had been waiting more than 18 weeks represents a major performance issue which was documented on the risk register. A progress report to address this indicated that the backlog had stabilised in the period March to August 2014. Managers were unable to provide us with

assurances or articulate implementation of the actions they were taking to manage this issue or information about what procedures patients were awaiting in line with the trust-wide plans to address the backlog.

- Between April and July 2014, there were 4,000 electronic discharge summaries awaiting clinical input. The trust was not able to show us how many of these were attributable to surgical wards, so we were unable to ascertain if this meant a number of GPs were not receiving important clinical information about patient admission and treatment.
- Some staff on Ward 7 North told us discharge worked well and they had not experienced a cancellation of a level 1 patient. Other staff spoke of bed pressures, emphasising that there were insufficient numbers of intensive care unit (ICU) beds which led to delays before and after surgery. Staff told us as there were no level 2 beds and a lack of ICU beds, which meant that unwell patients had to stay on the ward if they were deteriorating. They felt there were patients inappropriately located as there was an insufficient number of critical care beds and some patients had been 'stepped down' too early.
- Staff told us that at least one patient per month was nursed overnight in recovery, rather than being transferred to the ward, and a clinical incident was raised each time this occurred.
- Staff spoke of some delays in discharging patients who were under the care of the ENT specialists and told us they raised clinical incidents each time this occurred.
- A business case was submitted to board at the time of our inspection to open six level 2 neurosurgical beds on Ward 11 West. The unit would be managed by the critical care team and have clinical input from the neurosurgeons.

Meeting people's individual needs

- We saw all the dementia patients had a food chart and were given assistance at meal times to ensure their dietary needs were met. Fluid intake was also monitored most of the time, although we noted some inconsistencies in the quality of the recording. The trust had dementia 'champions' who were available to provide support and guidance for both patients and staff. A Butterfly Scheme for patients living with

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dementia was used in the ward areas. The scheme gave staff information about the patient's likes, dislikes and choices and helped staff manage the care of patients with dementia in a sensitive and person-centred way.

- The hospital had clinical and support staff who also worked as translators and were able to offer instant access to language support.
- Arrangements were made to ensure patients were treated in single-sex areas throughout the wards and theatres we visited. There was an admissions lounge in theatres, eight consulting rooms, with separated male and female waiting areas.
- Elective admissions were staggered throughout the day so it was possible to promote flexibility for patients, although most patients asked or were requested to arrive between 7am and 7.30am to suit the running of the theatre list.
- Emergency patients admitted via A&E took priority and could be admitted at any time. Staff told us these emergency admissions resulted in surgical outliers, that is, patients being placed on other surgical or medical wards.
- A board round pro forma was used by the multidisciplinary team twice-weekly to review the social and medical status of patients aged over 70.
- A noticeboard outlined the various multi-faith services available with timings for specific prayers and services. Patients also had access to one-to-one support from the chaplaincy service.
- We saw evidence of multi-faith services available with timings for specific prayers and services.
- Patients' privacy and dignity were respected as male and female patients, often wearing theatre gowns, had separate waiting areas in the theatre reception.

Learning from complaints and concerns

- We saw information leaflets and posters about the Patient Advice and Liaison Service (PALS) and how people could make complaints displayed near the nurses' station in most surgical ward areas. However, ward staff told us they received no formal training in complaints investigation.
- Staff told us how patient feedback about their concerns resulted in changes to extend quiet and protected meal times.
- We noted there had been a monthly increase in complaints year-on-year between quarter one, April to July 2013 and 2014 in the division of surgery, cancer and

cardiovascular sciences from 6% to 12%. In quarter one of 2013, the complaints trends on surgical wards were: poor clinical care, poor nursing care, appointments, delays and cancellations and ineffective treatment and admission, discharge and transfer arrangements. In quarter one of 2014, the trends were noted to be: poor clinical care, poor nursing care and ineffective treatment, appointments, delays and cancellations, and communication and information to patients (written and oral).

- Ward matrons at Charing Cross Hospital told us they received low numbers of complaints, averaging one to two per month. Ward matrons shared lessons learnt from individual correspondence with patients to staff by email and these were discussed at monthly team meetings. Senior nursing staff regularly shared complaints, concerns and compliments with staff on a monthly basis.

Are surgery services well-led?

Requires improvement

The failure to take sufficient steps to ensure that the 'Five steps to safer surgery' checklist was embedded in practice and the failure to take sufficient proactive initiatives to reduce the high numbers of falls impacted negatively on surgical services ability to demonstrate that it was being well-led.

However, staff feedback on surgical wards about the nurse leadership was unanimously positive. Staff spoke of an open and candid culture in which problems and emerging concerns were escalated to senior management without hesitation.

There were some governance arrangements for auditing and monitoring services and evidence of actions or learning from clinical governance meetings, including accountabilities for change and development where available. Long-term plans for services at Charing Cross Hospital had been articulated, discussed with staff in open forums and agreed with relevant stakeholders.

Vision and strategy for this service

- The trust had a clinically-led vision for surgical services at Charing Cross Hospital and most staff we spoke with were aware of this.

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- The trust had developed a clinical strategy for 2014 which described long-term plans for all trust activities. In relation to the surgical services at Charing Cross Hospital, the focus was to centralise most day case and elective surgery to this site.
- We were told by divisional management staff the strategic direction had been agreed with the local clinical commissioning groups and other stakeholders.

Governance, risk management and quality measurement

- The trust had restructured its governance arrangements within the last year and this meant surgical ward areas were managed within the division of surgery, cancer and cardiovascular sciences, while pre-assessment and theatres were now in the investigative sciences and clinical support division. Senior staff told us this had no impact on the running of services, though some staff told us of difficulties with arbitrary decisions, as the two divisions had separate budgets.
- All specialty areas maintained their own risk register, and the risks deemed to be the most significant were escalated to the trust's overall risk register. Ward matrons we spoke with were aware of risks that had been escalated on this register and told us they were encouraged to identify and escalate risks.
- There were identified clinical governance leads at divisional level, with the heads of service being accountable at divisional level for clinical governance within their areas. All staff on shift were expected to attend, and these meetings were scheduled in advance to ensure staff availability and that there was provision for emergency theatre cases to take place. Discussions were open and encouraged contributions from staff, and included the 'Five steps to safer surgery' checklist, recently reported incidents, complaints and overall theatre performance.
- There were monthly clinical governance meetings on the surgical wards at which incidents, risks, audits and adherence to guidance were discussed, as well as joint divisional meetings for senior nursing staff.
- Divisional management teams told us that the medical director discussed serious and moderate incidents every Friday with senior management. However, these meetings were not minuted so we could not identify what actions were taken.
- Lead nurses collated the monthly harm-free care report which identified nursing quality indicators and included

a range of measures, such as pressure ulcers, falls, hospital-acquired infections, catheter-acquired urinary tract infections, complaints, compliance with intentional rounding (comfort rounds). Each ward was benchmarked and results were reported to the board on a monthly basis.

- Cost improvement plans were risk-assessed by the clinical team and reviewed at the quality committee before being agreed to ensure patient safety implications were considered.
- The July 2014 divisional complaints reports stated that complaint themes were not reviewed alongside incidents. Therefore, it was not clear how integrated this system was.

Leadership of service

- The failure to take sufficient steps to ensure that the 'Five steps to safer surgery' checklist was embedded in practice and the failure to take sufficient proactive initiatives to reduce the high numbers of falls impacted negatively on surgical services ability to demonstrate that it was being well-led.
- The leads for each clinical service area, or chief clinician, worked across the three locations of the trust.
- There was a strong leadership culture within nursing. Senior nursing staff and ward matrons led by example and demonstrated their personal accountability for the service and their staff. All staff we met said they were proud to work for the trust, their ward, and in their specialism.
- Some surgical ward areas kept a record of visits from the executive and non-executive directors and staff spoke positively about support they received from executives of the trust.

Culture within the service

- Staff spoke of an open and candid culture in which problems and emerging concerns were escalated to senior management without hesitation.
- There were no whistleblowing cases open at the time of the inspection. Staff we spoke with were aware of the trust's whistleblowing policy.
- Ward staff told us senior staff were open and created a positive teamwork culture, with ward managers visited weekly by their managers
- Junior and trainee surgical medical staff, who had started their rotations three weeks before we inspected the trust, told us they felt well-supported by





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consultants. However, findings from the 2014 General Medical Council trainee survey highlighted themes which had negatively impacted on surgical trainees, including induction, feedback, adequate experience and access to education resources. The chiefs of service for each area told us they had implemented a range of actions to address these concerns and were monitoring feedback from trainees.

Public and staff engagement

- There were weekly consultation meetings with staff over a two month period in 2014 regarding the clinical strategy.
- The clinical health psychology department led a number of interventions to support staff, including Schwartz rounds (sessions for staff from all disciplines to discuss difficult emotional and social issues arising from patient care), mindfulness for staff and patients, and reflective practice for clinical nurse specialists.
- Ward staff in surgical areas spoke about regular team-building events.
- Feedback was provided to nursing staff via “Prescription” to acknowledge good performance in harm-free care. ‘Patient and people prescription’ for staff highlighted good achievement with nursing-sensitive indicators on surgical ward areas.
- Results from the real-time, electronic patient feedback system, ‘I track’, was monitored and results were fed back to ward staff. Some ward areas were repeatedly scoring lower than the trust average for patients being involved in their care. The divisional management team did not outline what work was planned to address this.

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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 critical care service at Charing Cross Hospital comprised a 15-bed intensive care unit (ICU), a 25-bed high dependency unit (HDU) and a mix of 'step down' surgical and medical wards with level 2 beds.

We visited all areas that cared for ICU, HDU and level 2 patients. We spoke with six patients, family and friends, 38 members of staff, including medical, nursing, allied healthcare professional and administrative and clerical staff. We also checked eight patient records and 10 pieces of equipment. The ICU had around 550 admissions a year and 4,500 bed days and these had slightly increased from previous years.

Summary of findings

There were issues relating to the medical staffing levels and bed capacity within critical care services at Charing Cross Hospital, although most other aspects of care and treatment were appropriate, with positive feedback from patients. There were also several important audit results that were not supplied to us; the lack of which meant that the hospital could not demonstrate that its critical care services were effective.

Staff were engaged and aware of how the service performed and learnt lessons. Some aspects of training, safety and governance required improvement or change and there was a lack of audit result information.

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Are critical care services safe?

Requires improvement 

There were issues relating to the level of medical staffing out of hours for the ICU and level 2 beds in the hospital, particularly regarding staff who were airway trained. We also had concerns about the availability of equipment and where this was stored. We found issues with life support training. Otherwise, staff in critical care services were safety-conscious and there was learning from deaths, improving safety and infection results as well as appropriate nursing staff levels.

Incidents

- There had been a recent trust wide change after a 'Never Event' at another of the trust's hospitals (a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented) of a nasogastric (NG) tube located in a patient's lung. This had resulted in x-rays now only being reviewed by ICU consultants or radiology, and a long-term plan to assess staff competencies on checking x-rays.
- There had been 60 incidents in the sub-division of critical care, anaesthetics and pain reported between April and June 2014. All of these had been graded as 'no harm', 'low harm' or 'near misses'.
- Most incidents were pressure ulcers, implementation of care and medicine errors with some reports related to infrastructure and equipment. In response to the issues relating to pressure ulcers, a pressure ulcer group had been formed across the critical care units in the trust which included tissue viability nurse input to improve wound care practice. This also included education on the unit at patients' bedsides and had resulted in reduced numbers of pressure ulcers.
- All staff were able to describe how incidents had been learnt from. This included unit meetings where incidents were discussed. Root cause analyses were completed on serious incidents and investigations of other incidents such as pressure ulcers were completed.
- There was a backlog of incidents in critical care that had not yet been investigated at the time we inspected. We were told this was due to the lead nurse being away and also being part-time. Incidents were being identified by senior nurses, but some incidents could only be

signed-off as closed by the lead nurse which was causing the backlog. However, we were assured that senior nurses were taking on board any immediate learning from incidents that had been occurring on the ICU if the lead nurse was not available.

- The incident reports we looked at covering the last two months showed that actions had been taken to prevent the incidents recurring in the future. After a patient fell, action was taken with the patient and staff to prevent a further fall (such as reminding the patient to use their call bell and removing clutter from their bedside). However, the actions being taken were mainly reminders to staff or increasing staff awareness of policies or practice rather than changes to procedures or protocols.
- Mortality and morbidity meetings took place every two months which discussed patient deaths and any learning derived from them, both from a medical point of view as well as the overall care, such as family and patient involvement in decisions.

Safety Thermometer

- The results from the NHS Safety Thermometer (a national improvement tool for measuring, monitoring and analysing patient harms and harm-free care) were displayed in all the unit and ward areas we visited, with good results on falls (750 days since the last one in the ICU). There had been a hospital-acquired pressure ulcer only nine days before our inspection, but only a total of four in 2014/15 (part year figure) when there had been 29 in 2013/14.
- In the ICU, the pressure ulcer assessment completion audit showed only 75% were completed and had been at this percentage most of 2014/15. Overall harm-free care was 87.5% in the ICU. However, a weekly walk round with a tissue viability nurse took place in the ICU and there was an action plan to improve patient care in this area, including training, email reminders of policy and enabling staff to openly challenge other staff members. Tissue viability competence was also assessed and there was a training programme for this area.

Cleanliness, infection control and hygiene

- All the equipment we checked had been cleaned and green stickers were attached to show it had been cleaned within the last 24 hours.
- Most of the areas we observed were clean and tidy. Infection control signs were used on isolation rooms if a

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patient had an infection. However, we did observe a used blood sample bottle that had been left on the top of a bin, (although staff disposed of this as soon as we reported it).

- We saw staff observe infection control procedures such as wearing personal protective equipment such as aprons and gloves when providing care, and hand-washing when entering and exiting different areas of the unit. Hand gel was available near each bed side and on entering or exiting each ward area we visited. Cleanliness and infection control audits were positive and the last hand hygiene audit in the medical HDU showed 100% compliance. Although the last hand hygiene audit in the ICU was 84%, it had been 100% in the last few months. The last cleanliness audit for the ICU was 98.5%.
- There was a low rate of methicillin resistant staphylococcus aureus (MRSA) and clostridium difficile (C. difficile) infection rates in the units. There had been 51 days since the last C. difficile infection, 541 days since the last MRSA infection in the ICU and more than 200 days since each infection was found in the medical HDU. The last catheter-related blood infection was February 2014 with a current rate of 0.8 infections per 1,000 days in July 2014. However, although MRSA screening was 100% in July 2014, it was 88% and 61% earlier in the year, although there was a trust-wide action plan to address this.
- There were infection control priorities in the ICU each month. In September 2014 these were aseptic non-touch technique and visual infusion phlebitis score.
- Many actions had been taken to maintain and improve central line-association blood infections. These included root cause analysis into any blood infections, specific staff training, and microbiology monitoring of blood cultures. This had resulted in only two blood infections so far in 2014.

Environment and equipment

- All the areas admitting level 2 and 3 patients had appropriate facilities.
- Six of the pieces of equipment we checked were all maintained. Daily checks of the resuscitation equipment and intubation trolleys were fully completed. Oxygen cylinders were in date and appropriately maintained. However, there was only one defibrillator covering half of the ICU when there was supposed to be two. We were

told the one missing was being serviced but no temporary replacement had been arranged. Another cardiac arrest trolley in the medical HDU had not always been checked daily in the last few months.

- Staff in the units were informed of how to use the equipment as part of their induction.
- Some equipment was stored on top of shelves that were high enough to need a step ladder to reach. Although a step ladder was available, this meant the equipment was very close to the ceiling and lighting, although the areas were clean. We also observed a fire door propped open by a bin. This was a breach of fire regulations.

Medicines

- All the medication cupboards were appropriately locked and medicines were stored appropriately at the correct temperature, including those that needed to be locked in a fridge.
- We observed appropriate administration of medicine, including requesting patients' consent, and medicine records were complete.
- All but two medicines we checked were in date.

Records

- Most staff commented that there had been issues with the trust's electronic data management system, such as patients being sent to the wrong areas for admission. However, staff stated that they had been trained to use the system and there were 'champions' to help other staff.
- All eight of the patient records we looked at were completed, including observation checks such as heart rate, and risk assessments such as skin integrity and venous thromboembolism (VTE or blood clots).

Consent and Mental Capacity Act and deprivation of liberty safeguards

- Staff were aware of their responsibilities under the Mental Capacity Act 2005, when they needed a best-interest assessment and where to find the relevant trust policies.
- There was an ICU policy on mental capacity which was up to date with guidance on assessing and mitigating the situation for patients with delirium and confusion.
- One patient had a best-interest assessment and deprivation of liberty application and these had been undertaken appropriately.
- Records demonstrated that wards used the psychiatric liaison team when necessary.

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Safeguarding

- Staff were aware of their responsibilities to safeguard vulnerable adults. They knew the safeguarding lead in the trust and how to report a concern to them. They were also able to show us the current safeguarding policy.

Mandatory training

- Staff told us they received regularly mandatory training and were up to date. We found those that required advanced life support training had received it. However, basic life support training in the ICU was low at 76% and 79% in the HDU, although the overall mandatory training in the medical HDU was 80.77% in July 2014.
- In critical care in general, overall mandatory training compliance was high at 94% with administration/ clerical staff at 80%, 83% for doctors, 88% for nurses, 75% for healthcare assistants and 100% for scientific and technical staff.
- New staff induction included some aspects of mandatory training such as intravenous therapy, aseptic non-touch technique, infection control and medicines management.

Assessing and responding to patient risk

- Although there were some concerns from a few staff members about caring for deteriorating patients, the National Early Warning Score (NEWS) system was in use on the HDU and level 2 beds. These were completed and patients were escalated to the outreach team when appropriate in line with the trust policy. There was also specific online training for staff regarding the NEWS system.
- The hospital followed the trust policy for managing deteriorating patients and this clearly stated what score patients required before they needed more observations and escalating to either the medical or outreach teams.
- There was no formal pathway between level 2 and 3 beds due to the number of areas where level 2 beds were located. However, teleconferences took place daily between the areas with critical care beds to manage the bed space for those patients needing escalating or 'stepping down'.

Nursing staffing

- Nurse staffing in the ICU was one-to-one for all level 3 patients, with two nurses being required for patients requiring multi-organ support. Twelve patients were

being cared for by 13 nurses and two healthcare assistants, despite two patients being level 2. There was a one-to-two nurse–patient ratio for level 2 patients in the HDUs and medical wards when we inspected. Staffing levels were monitored so if there were unfilled shifts at another site, staff elsewhere could fill in if numbers allowed.

- Nurse staffing levels had been worked out using an acuity tool. The acuity tool showed there were no patients with complex needs in the ICU and we observed that this was the case. Discussions were held between the lead nurses at each ICU site twice-daily to ensure there was adequate staffing.
- A supernumerary band 7 nurse was on shift on the ICU as nationally recommended, although they sometimes took on a patient to care for if there was a lack of nursing staff on the shift. However, we were told this had only happened once in eight months.
- All staff had an induction which included an orientation on the unit. This was tailored for bank (overtime) and agency staff so they became familiar with the unit before they started work. Bank/agency nurses were more supervised by senior nurses, especially if they had not worked on the unit before. Senior staff estimated that at least a third of bank/agency staff they used regularly worked on the critical care units. There was a high use of bank/agency staff, although this was partly to cover new staff's supernumerary period. Therefore, the use of agency staff was far higher than the vacancy rate, although the vacancy rate was still high at 10%.
- Nursing staff were rotated around the three hospital sites so, if one site was short, staff could be moved if necessary. This was reflected in their contract terms and job description and was covered in their induction.
- There were two members of the outreach team who covered 8am to 6pm which was an increase from earlier in the year. There were plans to increase their hours to 8pm and add an additional member of staff.
- All new nursing staff had a supernumerary period, depending on their previous experience and competencies, and were first given the least-complex patients when they began working on the units.

Medical staffing

- Middle grade doctor vacancies were at 25.8% in critical care at the hospital with a 14.8% vacancy rate for trainee doctors. As a result, there was not always a registrar available out of hours on the ICU, which meant cover

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was sometimes by two junior doctors, the most senior being a core trainee 2 (CT2) covering 11 patients in the ICU. Although there was an on-call consultant who could arrive within 30 minutes to deal with referrals until their shift ended, this situation meant immediate medical support was not always appropriate for patients' acuity. Although the junior doctors had received tracheostomy training early in their time on the ICU, they had not yet done ventilation training at the time we inspected. This meant there was a risk of reliance on the on-call consultant to deal with some medical emergencies. This also meant the consultant was often staying late (until midnight, particularly Thursday to Sunday) due to the lack of a registrar. Staff felt the plan for a neurological HDU would encompass additional registrars being allocated to critical care but said recruitment was slow due to each additional member of staff having to be individually approved by senior managers of the trust.

- Although there was a full-time medical consultant dedicated to the medical HDU, there were no critical care medical staff dedicated to the HDU or other level 2 beds. Therefore, these wards were reliant on the on-site team (which comprised two site practitioners who were not airway trained) and advice from ICU staff for airway management out of hours, and the outreach service during day hours. Although there were two anaesthetists out of hours covering theatres, they were not ICU trained. In addition, there was only a general medical registrar and two senior house officers covering the wards out of hours who were also not airway trained. This was despite the A&E reducing to a UCC at Hammersmith Hospital, and staff confirming there had been a higher admission rate at Charing Cross Hospital in the first two days since. The site practitioners were also involved in bed management out of hours, which was causing additional strain on the medical resources at this time as they commented that pager calls were constant.
- Handovers took place at the end of each shift. We observed a handover on the ICU between the medical staff and this covered each patient including what their plan was for the next shift and what to do if there was an emergency. There was open communication between the doctors and the consultant if there were any questions. Ward rounds occurred twice daily.
- Most consultants on the ICU were trained intensivists but two were anaesthetists. Overall, there were seven

consultants dedicated to the ICU, of which two were locums but had experience with the trust previously and had planned to be at the trust long term. Two consultants covered the ICU during the day which meant, at worst, a 1:7.5 consultant-patient ratio which met national guidance.

- As some patients required transferring between the ICUs at the trust, there was a transfer policy to follow. This included ensuring that at least a registrar anaesthetist accompanied patients who were intubated. To ensure medical staffing levels were appropriate, they would call in at least an anaesthetic consultant to cover this.

Major incident awareness and training

- Staff were aware of the units' major incident plans. They were able to explain how they would react in an emergency, such as a terrorist attack or train crash, and how they would 'step-down' the least-dependent patients so there was room in the ICU to take additional patients as the hospital was a major trauma centre. They would also call in as many staff as possible and increase overall bed capacity. The situation would then be reviewed each shift.

Are critical care services effective?

Not sufficient evidence to rate 

There were several significant audit results that were not supplied to us; the lack of which meant that the hospital could not demonstrate that its critical care services were effective. However, staff within critical care services followed up to date national guidelines for treating patients, with appropriate multidisciplinary clinical input and competent staff.

Evidence-based care and treatment

- Although there were concerns from a few staff that national guidance was not always followed, we found National Institute for Health and Care Excellence (NICE) and other guidelines were being followed, including the Difficult Airway Society guidelines with priorities set according to guidelines where compliance with audits was lower.
- The trust's critical care policies such as catheter care, wound care, nutrition/food, bowel management, daily

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checks/nursing and risk assessments, admission documentation/property and discharge documentation, were up to date with current guidance and available on the trust's intranet.

- Staff told us they were kept up to date with national guidelines in a number of ways, including audits, unit meetings and while working at the patients' bed side as part of a multidisciplinary team.
- Pathways were in place to escalate patients to the ICU if necessary.
- Records showed appropriate guidance was followed in the event of a fall, such as post-fall observations, doctor attending and incident reported.
- Over 95% of patients were discharged within the time recommended in NICE guidelines, which was better than the national target.

Pain relief

- All the patients, their families and friends we spoke with told us they were happy with the pain relief received and patients said they were able to get pain relief when they needed it.

Nutrition and hydration

- Patients, their families and friends told us they were happy with the food and that drinks were always available and within reach. They said patients were supported to eat and drink by staff if needed.
- 90% of patients had a nutritional assessment completed and patients requiring intervention from a dietician were assessed by the ICU's designated dietician.

Patient outcomes

- The outreach team told us they could not produce any data to show how effective they were. They said this was due to having no national indicators to comply with. They said there would be severe difficulties in showing their effectiveness considering the small amount of interventions they had in a patient's care pathway. However, they did have targets to achieve, such as attending calls within 10 minutes.
- The trust submission of its own data reported figures from the critical care network for April to June 2014. These results showed the unit had a better (or lower) mortality rate than comparator units and better (lower) rates of unplanned re-admissions.
- The unit had historically been benchmarking its outcomes through a North West London collaboration

of ICUs. These results showed an overall compliance of 79% with issues such as lack of bed capacity, discharges overnight, lack of patient participation survey and Ventilator Associated Pneumonia/Central Venous Catheter compliance. These issues had also been highlighted 12 months previously.

- The critical care team were currently involved in a number of audits, including the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and other audits such as sepsis, stress ulcer prophylaxis, severe acute respiratory infection and central line-association blood infections care bundle. Junior doctors were also involved in a number of audits, including fasting before surgery, decision-making involved in ICU referral and tracheostomy for trauma patients. We were told actions were taken by the trust from these audits such as capnography extended to each bed space, establishing a critical care group, increasing the amount of bed space, having site manager meetings more regularly and relocating level 1 patients to side rooms to ensure there was not a mixed-sex breach. However, we did not receive the results of these audits, despite requesting them, therefore could not assess if appropriate action had been taken.
- We were told the ICU participated in the National Cardiac Arrest Audit, but despite requesting the findings, we were not provided with this evidence. Therefore, we were unable to confirm if the ICU participated and what the findings of the audit were.
- The Potential Organ Donor Audit showed the referral and involvement rate was high compared to the national average.

Competent staff

- We found staff had the necessary competencies to deliver care in the ICU, HDU and level 2 beds. Relevant senior members of staff had completed advanced life support training and consultants were trained in airway management. Nurses were also critically care trained, including those who were caring for patients in level 2 beds outside of the ICU and HDU. The training was part of a six-to-eight-month programme for experienced nurses and a year-long programme for newly qualified nurses. A specialist ICU course was also provided which had two intakes a year. Other courses provided included neuroscience, trauma and mentorships.

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- Staff told us they had appraisals and this was relevant to their role. The appraisal records we looked at showed nearly all staff were up to date with their appraisal with only nine outstanding out of 54 across the trust in critical care. Only two staff members out of 28 still required an appraisal in the medical HDU. There was a clear career progression pathway for nurses with additional competencies required at each stage, such as mentoring and critical care specific courses.
- Staff told us they were able to take on additional studies such as master's degree courses.
- Staff were given competency training to care for patients in critical care beds in the hospital, such as situation training in difficult intubations.
- Doctors in the ICU had training in medical emergencies, tracheostomies, desaturation and inotropes. This was prioritised for new staff to ensure they dealt with the most common scenarios as early in their training as possible.
- As there was no use of IntelliVue Clinical Information Portfolio® (ICIP) – the electronic patient records in the other trust ICUs. There was a specific induction pack created for new staff at Charing Cross Hospital ICU to ensure they were aware of how to use and record in the patients' paper records at this site. There was also a specific induction pack for another of the wards that had level 2 beds that was specific to the patients they admitted and treated.

Multidisciplinary working

- There was good multidisciplinary team working in the ICU, with a meeting every morning at 8.30am and team input during the week and at weekends, such as from physiotherapists and pharmacists.
- The medical HDU handovers were multidisciplinary and included doctors, physiotherapists and nurses. Multidisciplinary team rounds occurred daily, while a weekly multidisciplinary team meeting involved an ICU consultant for those patients who were expected to have a long stay.

Are critical care services caring?

Good 

Almost all the patient feedback we received was positive and we observed staff treating patients with compassion,

privacy and dignity. Patients, their families and friends were involved in their care, with explanations given by clinicians in ways they could understand. Emotional support was available to patients if needed.

Compassionate care

- We received mainly positive feedback on services from patients, their families and friends. This included that privacy and dignity were maintained, for example, by closing curtains when washing a patient. One patient described their care as “out of this world”. Another family member described the care as “unbelievable – far better than possible”.
- We observed kind and considerate care from staff. During handover, we observed staff introducing themselves if the patient was awake.

Patient understanding and involvement

- All but one patient said they felt involved in their care, including making treatment decisions with specific reference to doctors. They told us care and treatment was explained to them in a way they could understand, including what treatment plan they had. If clinicians could not inform a family member about something, such as time of recovery, it was explained why they could not do so. If a patient or family member had questions, these were answered by staff.
- When we observed the medical handover, the wishes of the patient, friends and family were at the centre of their care, with discussions about do not attempt cardio-pulmonary resuscitation (DNA CPR) permission and contacting the family if there was a change in treatment plan.
- Nurses were named above beds so patients, their family and friends knew who was responsible for their care.

Emotional support

- There was a psychiatric liaison service available for patients and relatives who required additional support during the day.
- Patients and families we spoke with told us they were offered emotional support by staff if they wanted it.

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Are critical care services responsive?

Requires improvement 

There was a lack of capacity for both the ICU and 'step down' wards for level 1 and 2 patients and capacity was not adequate as there was high bed occupancy and patients were cared for as outliers in non-critical care areas.

Complaints were not always learnt from, however, the service was responsive to vulnerable patients, their families and friends with the facilities, information and support they provided.

Service planning and delivery to meet the needs of local people

- Accommodation was made available for friends and families of patients if they needed it.
- There was a reduced need for the on-call ICU consultant to deal with referrals out of hours as there were reduced surgical lists with no electives after 10pm.
- Although there was an admission criteria for the medical HDU, we were told they were receiving inappropriate admissions such as patients with organ failure. However, we were informed that further work was being done on care pathways within critical care.
- The case mix for the ICU was increasing, with more patients requiring five-organ support in July 2014 and a trend of an increase in three- and four-organ support in the last year. This meant the condition of the patients admitted to ICU was poorer than previously and therefore needed a higher and longer amount of medical intervention.

Access and flow

- There was an overall lack of capacity for critical care patients, particularly to 'step down' from level 3 beds to level 2 and 1 beds. The ICU bed occupancy was around 90% in the last three months, despite additional beds recently being opened, and only one bed was available when we inspected. National research demonstrated that an occupancy over 85% presented a risk of care being compromised. However, overall bed occupancy in 2014/15 was 80.3% to date. There was rarely a bed available in the ICU or medical HDU in the last month and never more than one at any time. Around once every two to three months a recovery bed in theatres was used for a level 2 patient and some of these stayed

longer than 24 hours before being transferred. Medical staff said they had not had an outlier in the ICU since August 2014 and the unit had never been full. However, the recovery ward had a level 2 patient for four hours on one of the days we visited due to a lack of space in the ICU. Staff also commented it was sometimes difficult to get patients transferred to the ICU. There were additional beds in the ICU that the service could open if there was a capacity concern. However, as staff were not immediately available to staff these, it meant using ward beds to care for level 2 patients. Senior managers in the critical care service said bed occupancy was high due to the unavailability of a neurological-specific critical care unit at the hospital.

- The medical HDU bed occupancy was around 85% in the last three months, with at least one patient being delayed at least 12 hours a week to 'step down'. There were also concerns from the outreach team that patients were being cared for on medical and surgical wards with outreach support when they needed level 2 beds.
- The hospital's ICNARC-like data showed only 2% of admissions were delayed for over two hours in July 2014, although this was 5% overall since April 2013 with some admissions cancelled altogether. In July 2014, 11% of discharges were delayed for over four hours, although this had been as high as 23% in February 2014. This reduction had been due to opening extra ICU beds. The current average length of stay in ICU was 4.5 days, although it was 6.7 between April and June 2014; and 4% of patients were readmitted within 48 hours. Some elective surgical bookings were cancelled due to a lack of beds, but this totalled only 32 cancellations since April 2013. There had only been two non-clinical transfers since April 2014. Out-of-hours discharges were 5% since April 2013, with 33 out of 677 patients discharged out of hours.
- All admissions and discharges into and out of the ICU had to be agreed by an ICU consultant and patients were also followed up by an ICU consultant after they were transferred out.

Meeting people's individual needs

- There was an alcohol liaison service for patients that needed or wanted it. Side rooms were available for

Critical care

patients with delirium and we observed appropriate care of patients with mental health needs, with staff taking extra steps to ensure their care was safe and met their needs.

- Visiting hours were flexible so friends and families of patients could see them. There was a clear and clean waiting area for families to wait to see their relatives and accommodation could be arranged by the hospital if they needed to stay overnight.
- A variety of information was available. This included: a business card with the main phone number, visiting hours and location of the ICU; information on MRSA, VTE, preventing pressure ulcers, clinical trials and the chaplaincy service.

Learning from complaints and concerns

- Senior staff told us that most complaints were dealt with informally by the service and they tried to prevent formal complaints if possible. We found there was conflicting information about the number of formal complaints received. We found the critical care service had only received one formal complaint in the last 18 months, although 11 were recorded against critical care/anaesthetics/pain in April–June 2014. ICU staff told us the service had not received any complaints recently. We also saw no evidence of formal and informal complaints being discussed during team meetings. This meant there was a risk that complaints were not being learnt from.
- The various leaflets on how to complain and who to contact with a concern were displayed, including the Patient Advice Liaison Service (PALS), the comments/suggestions form and the contact details for making a formal complaint. A comments box was available at the ICU reception desk.
- Following concerns raised by critical care patient groups regarding noise and light, the service had started to provide ear plugs and eye shields to patients.

Facilities

- Telephones were available at each bed space so that families and friends of patients could call the nurse caring for that patient at any time.
- There was an area next to the ICU that was not being utilised for bed space at the time we inspected, despite the bed capacity pressures. We were told this area could not be used because it could not be staffed.

Are critical care services well-led?

Requires improvement



The inability of senior management to produce significant audit results to demonstrate the service's effectiveness impacted negatively on it being well-led. Although some staff were unaware of some parts of the vision and strategy of the service, the leadership team had identified how the service needed to develop and improve, including where its risk areas were. There was a positive staff culture, including feedback on engagement and leadership.

Vision and strategy for this service

- Staff had an awareness of the issues and risks that were affecting the critical care unit and understood their role in improving the service. However, other than the reconfiguration of services, there was not an awareness of the wider strategy for the critical care services or the trust's vision.
- Staff were aware of the long-term plan to close the critical care beds at the Charing Cross Hospital and the local leadership were planning for this by adding beds to St Mary's and Hammersmith Hospitals.
- The critical care leadership team's vision included reviewing the outreach support at all sites.

Governance, risk management and quality measurement

- Senior management did not submit to us important audit results to demonstrate the service's effectiveness, despite us asking.
- There were appropriate governance arrangements for the ICU with monthly divisional meetings on quality and safety. The medical HDU and level 2 beds outside the ICU were not under the same governance structure as the ICU. In addition, the outreach teams were not part of the critical care department's governance arrangements, although they were part of the same division. There was also no parity between the two outreach teams at Charing Cross and St Mary's Hospitals. The senior leadership of the critical care service felt this was causing issues. An attempt to reconcile this issue had not been successful, but we were told a further attempt was being planned for the future.

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- The critical care services contributed to ICNARC, took part in audits, monitored their performance using dashboards and the Symbiotix Agency, and was part of a Critical Care Network.
- The service had an up-to-date risk register which included the risks of delayed discharges, lack of capacity and medical staff vacancies, with mitigating actions either in place or in development. However, the lack of level 2 beds had been on the risk register since 2008, with no estimated completion date.
- Monthly quality board meetings took place at divisional level and a new critical care committee had recently been set up to provide quality and governance management for the department.
- Clinical governance newsletters were sent by the division to staff, which included updates on guidance, learning from incidents, pressure ulcers, and complaints. There had been three of these so far in 2014.

Leadership of service

- Staff felt able to approach their immediate line manager and felt supported at executive level, particularly by the new chief executive and chief operating officer. The leads within critical care told us the service was more of a priority within the trust than it had been previously. They gave an example of how an issue was raised regarding junior doctor induction and it was dealt with by the chief executive almost immediately.
- All members of staff we spoke with were particularly happy with the support by the general manager for critical care. One staff member said their local and divisional leadership always tried to solve their work-related problems.
- Staff were aware of the trust leadership's 'Back to the floor' initiative, which was part of the executive team's attempt to directly find out what the concerns and issues were in individual areas and departments.

Culture within the service

- Staff reported a good culture and team working within the critical care service. ITU staff had been nominated for an internal 'Oscar' award. There was also a 'Make a difference' scheme and 'Instant recognition' awards to help improve staff morale.
- Staff turnover was high at 20% and sickness was just above average at 4.3%.



Public and staff engagement

- Staff reported feeling engaged in how the critical care services performed and met patient needs. Unit meetings reviewed performance and incidents. A staff suggestion box was also available and team-building development days took place.
- Staff were involved in audits, including of NICE guidelines.
- Quarterly patient/relative focus groups took place with actions taken such as patient diaries, improving the waiting area and improving food/drink facilities. Of the meeting minutes we saw, at least five patients or their family and friends attended.
- The latest staff engagement survey showed that 39% of staff were positive overall about care and treatment.

Innovation, improvement and sustainability

- The critical care service was involved in a number of research projects, including lung/safe, VTE, and blood unit use. These were analysed and compiled by a set of research and clinical audit managers who were dedicated to the critical care unit.
- Staff were able to give examples of changes in practice that led to service improvement. This included a change of temperature probe as staff were complaining they could not read some patients' temperatures with the previous model.

End of life care

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

Information about the service

The Charing Cross Hospital specialist palliative care team (SPCT) comprised a palliative care consultant and three clinical nurse specialists. There was also a medical palliative care lead and a nursing team leader, whose roles encompassed the trust's three acute hospital sites. They were part of a SPCT that covered Imperial College Healthcare NHS Trust's acute hospital sites: St Mary's Hospital, Charing Cross Hospital and Hammersmith Hospital. As such, they shared policies, practices, documentation and held joint multidisciplinary team meetings.

The Charing Cross Hospital SPCT was involved with 1,129 cases in 2013/14; around 50% of the hospital's deaths. The team's input ranged from giving advice and support to ward staff on the management of palliative care for patients through to directly assessing and monitoring complex palliative care cases.

The SPCT visited patients on a variety of wards, principally oncology but also older people's and stroke wards. They liaised with ward staff, patients' families and community services with the aim of ensuring that patients' palliative care was delivered efficiently and in accordance with patients' wishes.

Summary of findings

There was an inconsistent approach to the completion of 'do not attempt cardiopulmonary resuscitation' (DNA CPR) forms. Action had been taken in response to the National Care of the Dying Audit for Hospitals 2013, which found the trust did not achieve the organisational majority of the indicators in this audit, but there was no formal action plan. However, the majority of the clinical indicators in this audit were met.

In line with national recommendations, the Liverpool Care Pathway for end of life care had been replaced with a new end of life care pathway framework that had been implemented across the hospital.

There was a recently developed end of life strategy and identified leadership for end of life care. The end of life steering group reported to executive committee. The SPCT were visible on the wards and supported the care of deteriorating patients and pain management. Services were provided in a way that promoted patient centred care and were responsive to the individual's needs. Referrals for end of life care were responded to in a timely manner and the team provide appropriate levels of support dependent on the needs of the individual.

There was clear leadership for end of life care and a structure for end of life care to be represented at board level through the director of nursing.

End of life care

Are end of life care services safe?

Requires Improvement 

There was an inconsistent approach to the completion of 'do not attempt cardiopulmonary resuscitation' (DNA CPR) forms. We reviewed 16 DNA CPR forms on five wards where patients were receiving end of life care. Eleven of these had been completed correctly and in full, but five had not.

The SPCT had not reported any serious incidents. When incidents relating to end of life or palliative care patients were reported by ward staff, these were investigated and action taken to reduce the risk of a similar incident recurring. Arrangements were in place for medicines to be provided if patient conditions deteriorated. The SPCT involved family members in decisions that related to their relative's care and treatment. Staff had attended safeguarding training but were unclear what level of safeguarding training this was or whether this was appropriate for their role. Staff felt confident about reporting safeguarding concerns and were aware of who to raise these with.

Incidents

- There had been no incidents, Never Events (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) or incidents requiring investigation that could be attributed to the specialist palliative care team (SPCT).
- Staff were aware of how to report an incident or raise a concern.
- Incidents were reviewed and discussed every two weeks at the multidisciplinary SPCT meeting to identify and share learning.

Medicines

- We looked at the records of patients receiving palliative care on a number of medical wards. Prescriptions had been written up in anticipation for medicines to be provided if patients' conditions deteriorated and needed medicine to relieve symptoms.
- Medicines were available on the wards and some were stocked on site. This meant they were easy to access when needed.
- The medical lead for the SPCT told us they were aware there had been issues that related to the prescribing of opioids within the hospital. These issues included

conversation of dosage when the drug was administered via different methods, such as injection or syringe drivers. To mitigate this risk the SPCT produced an opioid conversion chart. This was credit-card sized and converted differing opioid doses to enhance patient safety. Feedback from the medical staff we spoke with were positive about its effectiveness.

- In response to the National Care of the Dying Audit for hospitals 2013, the trust were trialling a system in relation to prescribing medication delivered via syringe drivers. This included the use of 'syringe driver prescription' stickers, which were pre-printed and aimed to make the identification of medications delivered via this method easy to identify. The pilot was being audited at the time of our inspection.
- Junior doctors told us they found the SPCT helpful and gave good advice about anticipatory prescriptions and pain management.

Records

- Some patients receiving end of life care had been identified as 'not for resuscitation'. Patients had the appropriate 'do not attempt cardiopulmonary resuscitation' (DNA CPR) form in their file so staff were aware of what action to take.
- We reviewed 16 DNA CPR forms on five wards where patients were receiving end of life care. Eleven of these had been completed correctly and in full, but five had not.
- Case notes demonstrated that patients and relatives were being consulted on a number of issues, including whether to attempt resuscitation. They also demonstrated that discussions were being held within the multidisciplinary team about patient care. This was documented in all 16 of the case notes we reviewed but had not been recorded on the DNA CPR form. We were told that these discussions and consultations were frequently getting lost in the case notes.
- The end of life care plans we looked at had all been completed and updated appropriately.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- The SPCT involved family members in decisions that related to a patient's care and treatment.
- Independent mental capacity advocates attended SPCT multidisciplinary meetings and contributed to discussions about treatment and discharge destinations, best interests and informal decisions.

End of life care

- In all notes we looked at patients' capacity to consent was recorded.

Safeguarding

- We were given a number of examples by medical and nursing leads for the SPCT which demonstrated they had raised and discussed concerns about potential abuse and vulnerability in multidisciplinary team meetings.
- Staff had received safeguarding training and appropriately referred cases to the hospital safeguarding lead. This included issues of financial abuse, concerns about patients' children, suicidal and elderly patients. Staff were able to easily locate the safeguarding referral form on the trust's intranet.

Mandatory training

- Staff were required to attend a three-day training course that covered mandatory training every three years. There were also other courses completed annually. Topics included infection prevention and control, fire safety, information governance and mental health and capacity.
- Attendance was monitored and recorded centrally within the trust. If staff had not attended, managers were contacted. Attendance was reviewed in annual appraisals and objectives could not be judged as 'met' unless staff had fulfilled this requirement.

Assessing and responding to patient risk

- We found three patients were on the new end of life care pathway framework. The documentation had been fully completed and the appropriate care was being implemented. We also found an example where hourly rounding (comfort rounds) had been completed to check on pain, breathing, bowel movement, bladder, mouth care and pressure areas. This was part of new documentation for this pathway of care.
- Ward staff we spoke with were complimentary of the new documentation, its relevance, simplicity and effectiveness to deliver care and respond to patients' needs.
- The results of the National Care of the Dying Audit for hospitals 2013 showed that 75 % of patients were identified for end of life care when they were dying. This was better than the England average of 61%. The trust

scored better than the national average for those patients who had been assessed within their last 24 hours, with 94 % compared to the England average of 82%.

- Ward staff told us the SPCT was visible on the wards and supported the management of deteriorating patients.
- Junior doctors told us they found the SPCT helpful and gave good advice about anticipatory prescriptions and pain management.

Nursing staffing

- There had not been an assessment to determine nurse staffing in the SPCT, current staffing levels were historical.
- There were a total of 7.8 whole time equivalent (WTE) clinical nurse specialists in the trust's SPCT. Three were based at Charing Cross Hospital. They were rotated annually across the sites to promote the trust-wide approach to palliative care.

Medical staffing

- There was a palliative care consultant based at the hospital and a medical lead within the SPCT that covered all three sites. This was in line with the Association for Palliative Medicine of Great Britain and Ireland recommendations, and the National Council for Palliative Care which states there should be a minimum of one consultant per 250 beds.
- There was an out-of-hours rota shared by the four consultants which ensured staff had access to the SPCT at all times.

Major incident awareness and training

- The medical lead for the SPCT told us they had completed the trust's major incident awareness training last year and had contributed to the major incident team's planning process.

Are end of life care services effective?

Good



The Liverpool Care Pathway for end of life care had been withdrawn and replaced with a new end of life care pathway framework that had been approved by the trust's end of life steering group and professional practice committee. Ward staff were trained and confident in the use of this pathway. Pain relief was appropriately managed.

End of life care

The National Care of the Dying Audit for Hospitals 2013 had made specific recommendations. While these were being addressed there was no formal action plan which documented the action that were to be taken to address the issues raised and timescales for completion of these actions.

All members of the SPCT had participated in an annual appraisal in the last 12 months. Ward staff from all of the wards we visited had attending training in end of life care. There were examples of multidisciplinary working and an on-call rota to ensure a member of the end of life team was available seven days a week.

Evidence-based care and treatment

- The SPCT withdrew the Liverpool Care Pathway in July 2013 which was as soon as the announcement regarding its withdrawal was issued by the Department of Health.
- A new end of life care pathway was subsequently produced by the SPCT and had been agreed through the end of life steering group which was chaired by the trust's director of nursing. This was rolled out across the hospital wards. It included a principles document and a multidisciplinary decision document. We were told this had been ratified by the professional practice committee and was due for imminent sign-off by the quality and safety executive committee.
- Ward staff told us that the SPCT had visited wards specifically to familiarise staff with the principles and use of the new care pathway documentation.
- The SPCT medical lead demonstrated annually to the trust's clinical quality assurance manager that the service was compliant with National Institute for Health and Care Excellence (NICE) guidance. Evidence seen during our inspection demonstrated compliance with relevant NICE guidance.
- The end of life care strategy was based on national guidance such as on the National Institute for Health and Care Excellence (NICE) quality standard 13, which defines clinical best practice in end of life care for adults and the Department of Health's National End of Life Care Strategy.

Pain relief

- We found pain relief medication had been assessed by medical staff and given to patients as appropriate. We found advice about pain management was being given to ward staff by the SPCT. Patient's notes demonstrated that pain was being managed appropriately.
- The new end of life care pathway documentation had been fully completed and the pathway had been implemented which supported pain management. We also found an example of hourly rounding had been completed, which included checking on patient's pain management (part of new documentation).
- We were told there were 40 syringe drivers (used in the administration of pain relief medication), which was adequate for the hospital. When patients were discharged, staff asked the community teams to put up the syringe driver and support once in the community.
- The relative of one patient told us they felt their loved one had their needs met and pain managed.
- The National Care of the Dying Audit for hospitals 2013 found that the trust achieved the key performance indicator for clinical protocols for the prescription of medications for the five key symptoms at the end of life.

Nutrition and hydration

- Nutrition and hydration needs were included in end of life care pathway documentation. We found three patients were on the new care pathway. The care pathway had been implemented and documentation fully completed. We also found an example of hourly rounding, including managing nutrition and hydration.
- Speech and language therapy assessments included an assessment of patients' nutritional needs.
- The National Care of the Dying Audit for Hospitals 2013, found that 66% of patients had a review of their nutritional requirements. This was better than the England average; while 77% of patients' hydration requirements had been reviewed, which was better than the England average of 59%.

Patient outcomes

- The SPCT participated in the National Care of the Dying Audit for Hospitals and received outcomes from this in May 2014. Actions were being taken on its key recommendations. These included auditing syringe driver use, having a board member with responsibility for end of life care and reviewing protocols for DNA CPR.

End of life care

We were told that action was being taken to address these recommendations but we were not provided with evidence of an action plan or which recommendations had been implemented

- The SPCT lead told us that a formal action plan in response to the National Care of the Dying Audit had been delayed because the trust wanted to produce a more comprehensive improvement plan for palliative care services. They had recently commissioned an independent service review that was carried out by Macmillan. The preliminary draft findings were received by the trust the week prior to our visit. It was the trust's intention to formulate its strategy and improvement plans on the basis of these reviews. We were told by the director of nursing that any actions from the CQC report would also be incorporated. The timescale for completion of this piece of work was based on receiving the CQC report.
- The National Care of the Dying Audit for Hospitals 2013 found that the trust had achieved better than the England average for seven out of ten clinical key performance indicators and scored worse for one indicator.

Competent staff

- There was a process of annual appraisal for all SPCT staff. Training attendance was reviewed in annual appraisals and objectives could not be judged as 'met' unless staff had fulfilled their training requirements.
- SPCT staff told us they saw part of their role as always being available to ward staff to give advice and share expertise. Ward staff told us they felt more competent as a result of this support.
- Ward staff told us that SPCT staff were easy to contact and responded promptly to their requests for support and advice. They also told us the SPCT had carried out training on using the new end of life care pathway documentation on the wards. Healthcare support workers were also able to tell us about the new documentation.
- Other ward staff we spoke with told us they had received additional end of life training. For example, through attendance on the postgraduate end of life care module or the four-day course run by the trust. We were told they felt supported by the hospital to do this which enabled them to provide support for junior nurses and healthcare support workers.

- The mortuary's anatomical technology pathologist told us they had provided training to the porters in the transportation and storage of bodies between the ward and mortuary.
- There was an induction process for new staff and bereavement study days were completed by staff. The patient affairs manager was visible at all sites to support staff, but was based at Hammersmith Hospital.

Multidisciplinary working

- Regular SPCT multidisciplinary team meetings were held and attended by a range of staff including nursing, medical and others from all three hospital sites that provided palliative care within the trust.
- Members of the SPCT also attended multidisciplinary discussion of cases, board rounds and ward rounds to provide clinical input for palliative care patients and to identify other patients who may benefit from the SPCT being involved in their care.
- SPCT members maintained relationships with external teams who provided palliative care such as the local hospice's multidisciplinary team by regularly attending meetings with them. They were also in contact with community health teams and attended the local authority end of life steering group meetings and meetings with local clinical commissioning groups.
- The SPCT liaised with carers and care homes and the lead dementia nurse for the trust. Care planning for patients was addressed within this wider support network. For example, mental capacity issues, treatment options and discharge planning which was the responsibility of the care of the elderly and medical teams.
- The end of life steering group met monthly and had representative from across the hospital, including junior doctors, allied healthcare professions, nurses, discharge teams, chaplains and governance teams. Its focus was on service improvement.

Seven-day services

- The SPCT provided a clinical nurse specialist service Monday to Friday between 8am and 5pm and medical cover was available on site Monday to Friday between 8am and 8pm.
- There was a palliative care consultant on-call rota out of hours. We were told that an average of three to six calls were received daily at the weekend through the on-call system, these were mostly for advice about pain relief.

End of life care

- Ward staff had the contact details of the on-call service displayed in nursing offices. Ward staff told us they felt supported by this service.
- The bereavement officer was available Monday to Friday 09.00 to 5pm..
- There were arrangements for relatives to visit the mortuary and to allow bodies to be released out of hours and during the weekend.
- Chaplains were available at evenings and weekends.

Are end of life care services caring?

Good



End of life services at Charing Cross hospital were caring to patients and their families. Patients and relatives we spoke with told us staff were compassionate and kind, and patients felt their preferences for care were respected.

We observed SPCT staff as caring and compassionate in all of their interactions with patients. The SPCT supported people's wishes and preferences for how they wished to be treated and cared for.

Compassionate care

- We spoke with three patients and four relatives. Patients and relatives told us they felt the SPCT and ward staff gave very good care. People told us they felt staff were compassionate and kind. Patients felt their preferences for care were respected.
- We shadowed a clinical nurse specialist from the SPCT who went to see an oncology patient and the parents of a young patient. The clinical nurse specialist placed value on people's wishes and preferences. They also explained things such as pain management and medication in a kind and caring way to patients and their families.
- The clinical nurse specialist told us they visited the wards and ensured palliative care patients were comfortable and that their ongoing needs were being met. They spoke with relatives in a kind, compassionate way in all of their interactions with them.
- We observed caring discussions between ward staff and the family members of a patient. Family members were complimentary about the care, which they felt was delivered with care and compassion.

- The SPCT told us about the need for them to work with heightened emotions sensitively and the importance of working with compassion at what was a difficult time for people.

Patient understanding and involvement

- The SPCT told us they saw part of their role as advocating for patients and their relatives. For instance, getting people single rooms on wards where this was the patient's choice.
- Patient notes demonstrated that the views of patients and their relatives were taken into consideration in the way they were treated and cared for.
- The SPCT had a policy of always supporting patients' choice of preferred place of care and preferred place of death, although community resources meant this was not always achievable. The team was successful with this choice 80% of the time.
- As well as promoting family/carers' involvement in patients' care, independent mental capacity advocates attended the SPCT multidisciplinary team meetings. This was to assist and support patients to make informed decisions about their care. Patients' wishes were documented on the SPCT multidisciplinary form for each patient and in case notes by ward staff.

Emotional support

- The clinical nurse specialists were all trained in psychology. They demonstrated the need to support patients, staff and relatives emotionally.
- The trust's end of life strategy stated that psychological support should be offered to people in the last days of life, however, no evidence was provided to demonstrate that this was achieved.
- SPCT multidisciplinary meetings discussed patients' emotional and psychological needs to ensure these were met.
- There was a counselling service available for oncology patients and their relatives and staff knew how to access this service.
- There was a staff counselling service available and staff we spoke with were aware of this service and how to access it.

End of life care

Are end of life care services responsive?

Good



The end of life care service was responsive to people's needs. The SPCT ethos and philosophy was centred on being responsive to people's needs and being accessible to wards who contacted them for support. Ward staff confirmed that referrals and requests for advice were responded to in a timely manner.

No complaints received by the hospital within the last year were attributable to the work of the SPCT. However, the SPCT addressed themes they found in complaints that related to end of life care through presentations to ward staff on managing sensitive situations and understanding issues facing patients and relatives.

Service planning and delivery to meet the needs of local people

- Ward staff told us the SPCT was responsive to people's needs and accessible to wards who contacted them for support. We were told that the team's capacity ensured that they were never in a position where they had to prioritise who they saw.
- The SPCT also measured the level of input they had with each patient. This enabled an understanding of how they had responded to individual needs. These were graded from 1 (offering advice and acting as a resource for ward staff) to 4 (directly assessing and monitoring complex palliative care) and 86% of referrals were graded as a 3 or 4.
- Single side rooms were available on wards and patients receiving end of life care would be accommodated when it was appropriate and rooms were available. The SPCT lead nurse told us their staff spoke to ward managers when they felt this option was more appropriate for patients. We found single rooms on wards were available to patients receiving end of life care.
- There were no time restrictions for relatives visiting patients receiving end of life care. Relatives were able to stay overnight with their loved ones when accommodated in a side ward (single room). Wards confirmed they allowed relatives to stay in single rooms overnight.

- Some single rooms we observed were old and worn. For instance, paint was faded and patchy and windows grimey on the outside.
- The hospital was able to offer relatives reasonably priced accommodation in a block of flats nearby. The trust's shuttle bus service ran between the trust's hospitals and was available to people staying there.
- There was free car parking to a family member of any palliative care patient.
- There were quiet rooms available on wards for holding sensitive conversations and for breaking bad news. We found these were basic but clean. Some rooms on the oncology wards had been refurbished to provide a more pleasant space.
- There was a telephone interpreting system available. We were also told that there was an internal interpreting resource available provided by bilingual healthcare professionals employed by the trust. If an interpreting service was needed for an uncommon language it would be outsourced. Staff we spoke with knew how to access the interpreting service.
- Mortuary viewing was available for relatives at all times through the site managers. There was a separate entrance for patients. The mortuary viewing area was subtly lit, well-maintained and pleasant.
- When a patient died, the hospital's electronic information system had a mechanism to cancel their future appointments and correspondence.
- There was a Macmillan information office on site. It contained advice for patients and was staffed part-time by a benefits advisor.

Access and flow

- There was a discharge team within the trust and we were told the SPCT's policy was to always support people's preferred place of care and preferred place of death. The team were involved with 95% of the hospital's fast-track referrals for discharge. The trust's aim was that funding for rapid discharge should be agreed within four hours and a placement found within 24 hours.
- The National Care of the Dying Audit for Hospitals 2013, found that the trust did not achieve the performance indicator that patients had access to specialist care in the last hours of life.
- We found two examples where funding had been agreed within this timeframe for patients who were awaiting

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discharge. We also found an example where a patient's condition had rapidly deteriorated to the point where a clinical decision had been made not to move them from hospital so they did not die in transit.

- We observed a clinical nurse specialist from the SPCT explaining the care home application process to a patient and their relative. The SPCT saw it as a priority to speed up the funding process for these applications.
- The team maintained relationships with clinical commissioning groups and local stakeholders such as community teams and hospices through attendance at meetings and multidisciplinary meetings. This gave them a better understanding of the funding issues and barriers for patients being discharged to their preferred place of care and preferred place of death. We were given examples where access to home equipment or hospice placements could be difficult depending on which borough people lived in. This enabled the service to respond more appropriately to discharge planning.
- The SPCT measured their success rate in achieving patients' preferred place of care and preferred place of death. This was 80% at Charing Cross Hospital.
- Capacity in the mortuary was managed. The mortuary maintained good links with patient affairs and staff were aware of how to contact relatives to remove bodies.
- The regular (non-rapid) discharge process was for a needs assessment to take place followed by a funding panel decision on funding and responsibility between health and social care services to improve this process.

Meeting people's individual needs

- Chaplaincy services attended the SPCT multidisciplinary team meetings at the hospital and input from all major faiths was available. The pro forma for recording all SPCT multidisciplinary discussions included addressing cultural and spiritual needs. The chaplaincy coordinated work between the three acute hospitals within the trust. We met a number of chaplains during our visit who were on wards speaking with patients. There were leaflets and information available about what was on offer at the entrance to the chaplaincy. There was a range of multi-faith services available.
- The SPCT liaised with carers and care homes and the lead dementia nurse for the trust. Care planning for patients was addressed within this wider support network. For instance, mental capacity issues, treatment options and discharge planning was the responsibility of the care of the elderly and medical teams.

- We were told the SPCT rarely had contact with patients with a learning disability. When they did, they immediately contacted the person's community support network and family to get up-to-date information about that person's preferences and needs.
- People's individual preferences were noted in the SPCT's hospital multidisciplinary meeting record. This included spiritual preferences, goals, social/family involvement and whether the patient had signed a DNA CPR form. We were told that, once this was completed, a sticker was placed in the patient's notes to inform staff. However, the hospital had run out of stickers at the time of our visit.
- The mortuary viewing area was in good condition and provided a calming space for people. There were tissues available in the viewing room and also in the patient affairs area, but there was no water or other refreshments available in either area.
- The National Care of the Dying Audit for Hospitals 2013 found that 39 % of patients had a spiritual needs assessment at the trust; this was similar to the England average.
- The Muslim prayer room was clean and well-maintained. The multi-faith room was also clean and well-maintained. There was a quiet space near to the chaplaincy which was peaceful, calming and subtly lit.
- Information about the chaplaincy was available on the wards. Laminated sheets were on display with photos and contact details of chaplains of different faiths. Information leaflets regarding Patient Advice and Liaison Service (PALS) and bereavement support were also available on the wards.

Learning from complaints and concerns

- No complaints received by the hospital within the last year related to the SPCT. Trust-wide, 4% of complaints related to patients receiving end of life care. The SPCT carried out an analysis of the general complaints data that related to end of life care and found issues such as bad communication and decisions regarding care and treatment were themes. A presentation addressing these themes was given to wards that provided end of life and palliative care to enable a better understanding of issues for patients and relatives.
- We were also given examples where the SPCT had liaised between wards when patients' relatives were unhappy with aspects of their care. We were told the

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SPCT's intervention fulfilled a supportive role for both relatives and staff when there were heightened emotions and difficult conversations about palliative care.

Are end of life care services well-led?

Good 

Action had been taken in response to the National Care of the Dying Audit for Hospitals 2013, which found the trust did not achieve the organisational majority of the indicators in this audit, but there was no formal action plan. However, the majority of the clinical indicators in this audit were met.

There was limited evidence of how the view of patients and their relatives were obtained.

There was a recently developed end of life strategy and identified leadership for end of life care. The end of life steering group reported to executive committee. There was an annual audit programme and the service contributed to national data sets. Staff stated action had been taken and some of this was evidenced during the course of our inspection, however, this had been taken in an ad hoc manner and not against an agreed action plan and not reported through a governance structure.

Vision and strategy for this service

- The end of life care strategy developed in 2014 by the end of life steering group was based on national guidance such as on the National Institute for Health and Care Excellence (NICE) quality standard 13, and the Department of Health's National End of Life Care Strategy.
- In response to the National Care of the Dying Audit, that found there was no executive lead for end of life. The director of nursing was identified as the executive lead for end of life care and chaired the end of life steering group from May 2014.
- The end of life steering group met monthly and had representative from across the hospital, including junior doctors, allied healthcare professions, nurses and chaplains.

Governance, risk management and quality measurement

- The National Care of the Dying Audit for Hospitals 2013 found that the trust had not achieved six of the seven of the organisational key performance indicators (KPIs) and made nine key recommendations for the trust. There was no action plan detailing the delivery of these key recommendations. We found during our inspection that action had been taken to address some of the recommendations but these had not been reported through formal governance arrangements.
- The end of life steering group reported to the executive committee through the director of nursing who was also the chair of the group.
- There was an annual audit programme and audits completed this year included syringe driver sticker audit, SPCT response times to referrals and hospice waiting times. Planned audits for later this year included Pro Re Nata (PRN, or as required) drugs administration, fast-track discharge and syringe driver set-up times. Some action plans had been developed following audits to address shortfalls.
- Audit results were presented at the monthly cancer directorate morbidity and mortality meetings. It was unclear how learning from audits was shared with other directorates in the hospital.
- The SPCT participated in the London Cancer Alliance (West and South London group) work programme including the palliative care and the psychological work stream, which aimed to share learning, practice and service improvements.

Leadership of service

- The SPCT had a medical lead supported by a consultant based at each hospital site. The team also had a clinical nurse specialist team leader, with clinical nurse specialists based at each hospital site.
- The SPCT team leader and medical lead regularly visited all three sites and were aware of issues relating to their service.
- There were some systems in place to ensure a consistency of approach by all staff caring for patients at the end of their life. For example, all ward staff we spoke with were aware of the new end of life care pathway documentation.

Culture within the service

- The SPCT leadership team told us they nurtured a culture of helpfulness, accessibility and openness. Ward

End of life care

staff told us they found the SPCT members to be accessible, helpful and approachable. We were also told they fulfilled an educational and advisory role whenever they were called on.

- The SPCT aimed to achieve a culture that had the same attitudes and values, culture and practice across all three hospitals. They held joint meetings and shared pathways, processes and documentation. They had also introduced an annual staff rotation between the hospitals for clinical nurse specialists.

Public and staff engagement






- The patient experience committee fed into the oncology patient experience group. Minutes showed that meetings were held every two months and patients were represented alongside trust leads and matrons.
- We were told by the SPCT medical lead that they had faced difficulty getting feedback from people who had come in to contact with their service due to the sensitive nature of death for people's relatives and carers. In 2011/12 the team tried to implement a patient questionnaire without any success. The team had recently approached a clinical psychologist to explore how feedback could be obtained.
- The clinical psychologist found that relatives reported that they were too exhausted following a bereavement to give feedback about the service. In response, the

service had recently completed a piece of work with information governance and patient affairs. This will involve the patient affairs team obtaining consent from relatives to send them a questionnaire six weeks after the death of their relative, asking for feedback on their experience of the service. As this initiative had only recently been introduced we were unable to assess its effectiveness or if concerns raised by relatives were addressed.

Innovation, improvement and sustainability

- To make improvements to the service participated in the National Council for Palliative Care's minimum data set collection. This information compared the service with other palliative care services and fed in to the trust's service review of palliative care services.
- Work had commenced in the development of a Commissioning for Quality and Innovation (CQUIN) framework that aimed to encourage healthcare providers to demonstrate quality improvements and innovation in relation to advanced care planning for end of life patients. One of the SPCT consultants spent one day a week focusing on developing and implementing a baseline audit. To support this work the hospital had commenced recruitment for a clinical nurse specialist on a one-year contract.

Outpatients and diagnostic imaging

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

Information about the service

The main outpatient clinic at Charing Cross Hospital is located on the first floor and has four clinic areas and 32 consulting rooms. The general outpatient department sees about 72,000 patients per year (60%) with the other 40% being seen in specialist clinics. The general outpatients department included a variety of specialisms such as oncology, endocrinology, gastroenterology, dermatology, neurology, podiatry and diabetes. There was also a phlebotomy service for outpatients.

We inspected the general outpatients, oncology and radiology departments. We spoke with 14 patients and two family members or carers. In addition, we spoke with nine members of staff including managers, doctors, nurses, administrators and receptionists. We observed care and treatment and looked at care records. Before our inspection, we reviewed performance information from and about the hospital.

Summary of findings

Full patient records were not always available to support consultations in clinics. The responsiveness of the department was particularly poor. The number of clinics had not increased in the last year despite an increase in patients. As a result, patients were having to wait longer to get an initial appointment and also had longer waits to be seen when in clinic. Doctors consistently turned up late for clinics without explanation. Managers we spoke with were unable to explain the process for monitoring performance and making improvement plans.

The hospital was not meeting its target of sending out appointment letters to patients within 10 working days of receiving the GP's referral letter; which we heard could take between three and five weeks. There were several problems associated with the issuing of appointment letters which caused unnecessary delay and inconvenience to patients.

However, there were enough nursing and medical staff in the department. Patients were treated with compassion, dignity and respect, and were positive about the care they received. Staff were focused on providing a good experience for patients and treated them with care and compassion.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good



Staff identified and reported adverse clinical incidents appropriately and learnt from the outcomes of any investigations. The department was visibly clean and staff adhered to trust infection control procedures. There were enough nursing and medical staff in the department to ensure appropriate care was provided and the majority of staff had completed mandatory training, including safeguarding vulnerable adults.

Medicines were always stored securely and regular medicine audits were undertaken. However, full patient records were not always available to support consultations in clinics.

Incidents

- Never Events are largely preventable patient safety incidents that should not occur if the available preventative measures had been implemented. The trust had not reported any Never Events since April 2013. Staff had access to the trust's online incident reporting form and were trained in how to use it. They told us they used the reporting tool when they needed to.
- Senior staff were able to talk through and show us reports of previous incidents that had occurred in the department and they explained the changes that had been made as a result.

Cleanliness, infection control and hygiene

- Clinical areas, toilet facilities and waiting areas were visibly clean and tidy. We were told that cleaning staff cleaned the clinic rooms daily and we found that cleaning schedules had been completed. We saw checklists and 'clean' stickers had been completed to indicate that areas had been cleaned.
- There were hand-washing facilities and hand gel dispensers in every consultation room and we saw staff washing their hands and using hand gel between treating patients. We saw weekly hand hygiene audit had been undertaken by the matron and, when non-compliance with hand hygiene protocols was found, feedback was provided to individual staff members.

- We found all the curtains in the department were disposable and had future dates attached to them indicating when they would need to be replaced.
- Staff we spoke with were aware of the trust's aseptic non-touch technique guidance which aimed to reduce the risk of infection. 'Bare below the elbow' policies were adhered to by staff in the clinical areas where examinations were taking place.
- Personal protective equipment such as gloves and aprons were available for staff use. We found staff using the equipment correctly when taking blood samples from patients.
- We found sharps waste bins in all of the clinic rooms were used correctly and none of them was more than half full. This meant the risk of staff receiving a needle-stick injury was reduced.

Environment and equipment

- The outpatient department was accessible to all patients, including those in wheelchairs or who had other challenges with their mobility.
- There was sufficient seating in all clinics. The chairs in the waiting rooms were suitable for people who had mobility problems. This reduced the risk of people falling as they attempted to get up and sit down.
- Staff told us there was always a 'floor walker' on duty at the entrance to the clinic to assist patients as necessary. We observed the floor walker greeting and supporting patients as they arrived at the clinic.
- Equipment was appropriately checked and was visibly clean. Staff told us there was adequate equipment available in all outpatient areas.
- We noted the resuscitation equipment in the clinic had been checked daily and had been regularly maintained.

Medicines

- Medicines were stored securely. In all of the eight treatment rooms we examined we found medication cabinets were locked. Staff we spoke with were fully aware of the hospital's policy on the safe storage of medicines.
- The department undertook regular medicine audits and we saw copies of these.

Outpatients and diagnostic imaging

Records

- Doctors we spoke with told us it was quite common for them not to have a full set of notes. One patient told us, “I had to wait two hours when I came here six weeks ago and they still didn’t find my notes, and now again I am waiting because they don’t have my notes”.
- Managers and staff told us a new IT system had been introduced a few months ago and, as a result, the availability of notes in clinic had reduced. Where a full set of notes was not available, the patient could be seen in clinic using a temporary record that did not include their full medical history. However, we noted that the full set of all 31 medical records for two of the clinics we visited was available. No patient was due to be seen using a temporary record.
- Managers we spoke with were not aware of the detailed figures for the availability of full sets of notes in the department.

Consent and Mental Capacity Act

- Patients told us they were asked for their consent and staff explained treatment before procedures were carried out. We examined 11 sets of patient notes and found that four of them did not record patients’ consent.
- Staff were clear about their responsibilities in line with the Mental Capacity Act 2005.

Safeguarding

- The department had up-to-date policies and procedures for safeguarding children and adults. This included having contact details for the identified adult and children’s safeguarding leads in the trust should staff need advice or guidance.
- The outpatients matron told us the department had not had any safeguarding issues or referrals in the last 12 months. The matron was able to demonstrate that the last safeguarding incident that had occurred had been managed appropriately and in line with trust policies and procedures.
- Staff were clear about what action they should take should they suspect a patient was at risk or the subject of abuse.
- We noted there was safeguarding information on the walls of the clinic for staff and the public.

Mandatory training

- The trust’s training records for the department showed 83% of staff had completed their mandatory training.

Mandatory training covered areas such as basic life support, conflict resolution, moving and handling, infection control, safeguarding, information governance and improving communication. Some staff who had attended basic life support training told us they knew how to apply it in practice.

- Mandatory training was provided either face-to-face or online, depending on the topic. We were told cover was provided to allow staff to attend mandatory training when required.

Assessing and responding to patient risk

- Staff told us all patients who attend the clinic were seen when they arrived in the department by the floor walker who would identify any patients who were unwell and take appropriate action to provide any additional support.
- We observed all 17 patients who attended the clinic during a 40-minute period were greeted by the floor walker, who offered them assistance and support.

Nursing staffing

- The department had undertaken a patient needs analysis to confirm the correct number of staff it needed to care for patients. The department had an establishment of four registered nurses (one of whom was on a career break) and seven outpatient care assistants (two of whom were on long-term sickness leave). The absence of these three staff over a long period of time meant that agency staff were regularly used in the department. Managers told us permanent staff were not only more cost effective but also had a better understanding of the practices in the department which consequently improved the outcomes for patients.
- The department had a senior nurse who had overall responsibility for maintaining the staffing rota and managing staffing issues to ensure clinics were appropriately staffed. We reviewed the staffing establishment in relation to the number of registered nurses and outpatient care assistants. There were four full-time registered nurses to cover four outpatient clinic areas. We found the outpatients department was adequately staffed based on the needs of the patients who attended.
- The matron and senior nurse for outpatients were supernumerary and not included in the department’s staffing numbers. However, they were able to supervise and assist staff as necessary.

Outpatients and diagnostic imaging

- Each clinic had a nurse who was responsible for making sure the patients' notes were complete, undertake any initial procedures, (such as weighing the patient), and act as a chaperone if needed. During our inspection we found all clinics had a nurse and a receptionist.

Medical staffing

- Staff told us every clinic was consultant-led. We found all the clinics on the day of our inspection had a consultant present, although they did not see all patients.
- Staff told us there was no rota setting out which middle and junior grade medical staff were expected to attend clinic to support the consultant. Some clinics had two or three junior doctors, while in two clinics we noted the consultant was the only doctor present. In those circumstances, it meant patients often had to wait more than an hour to see a doctor.
- There was an insufficient number of medical staff in some of the clinics to meet the increased demand for appointments. This meant clinics were being over-booked and patients had to wait longer to be seen.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Clinical practice in the outpatient department followed National Institute for Health and Care Excellence (NICE) guidelines and patients were satisfied with the treatment they received. However, there was only one pain clinic in the entire trust and it had a long waiting list. Therefore, patients may not have been able to access specialist pain treatment and support when they needed it. Letters to GPs following clinics were going out too slowly and clinics did not operate outside of normal business hours, making access for patients more difficult.

Evidence-based care and treatment

- Staff told us national guidelines such as NICE guidelines, were followed where appropriate. For example, the care pathway for patients with diabetes and patients with ophthalmic conditions. Clinical staff we spoke with demonstrated knowledge of the NICE guidelines relevant to their specialist areas.

Pain relief

- Patients told us staff had spoken to them about pain control and explained they should contact their GP or the department's medical secretary if they experienced pain after leaving the clinic. Staff told us there was only one pain clinic in the entire trust and it had a long waiting list. This meant patients may not be able to access specialist pain treatment and support when they needed it.

Patient outcomes

- Staff told us diagnostic test results were available promptly to support consultations. We spoke with the radiology department manager who told us the department was well-staffed and able to provide reports electronically within 48 hours, 98% of the time. This meant patient treatments were not delayed. The radiology manager and staff told us that, although they were able to deliver a good service to patients, this involved working weekends and long hours which was not sustainable over time.

Competent staff

- Staff we spoke with were competent and knowledgeable about their specialist areas.
- All staff had participated in an annual appraisal in the last 12 months. During their appraisal, staff were asked to identify how they could develop their performance in the future.
- All newly appointed staff in the department had completed an induction programme which included mandatory training as well as an overview of trust practices and procedures.

Multidisciplinary working

- We saw some examples of multidisciplinary team working, for example, in the oncology clinic where there was a good working relationship with Macmillan nurses. This meant patients had a good level of continual support during a difficult time in their lives. We also found that staff had a good knowledge of how to put patients in touch with other agencies such as social services.
- We found that, although there were many volunteers who were willing to support the trust in its work, they were not used in the outpatients department.

Outpatients and diagnostic imaging

Seven-day services

- The outpatients area did not provide a seven-day service. All outpatient clinics were provided Monday to Friday between 9am and 5pm. There were no early morning or late evening clinics for people who work during the day.

Are outpatient and diagnostic imaging services caring?

Good



Patients were positive about the care they received. Doctors, nurses and healthcare assistants spoke to patients in a dignified way; they greeted them, introduced themselves by name and apologised if there had been a delay when escorting the person into the consulting room.

Staff treated patients with care and compassion. Patients were greeted by a floor walker who ensured their specific care needs were identified and supported. Patients did not always find it easy to contact secretaries for specialist clinics if they had a query about their appointment.

Compassionate care

- Patients were treated with compassion, dignity and respect. For example, we observed reception staff being polite and taking time to explain things to patients and their relatives.
- We observed doctors, nurses and healthcare assistants speaking to patients in a dignified way; they greeted them, introduced themselves by name and apologised if there had been a delay when escorting the person into the consulting room.
- Most patients told us their experience in the department was positive. One person said, “it’s better than any other hospital I have been to, the consultant was very caring”.
- Patient consultations took place in private rooms and we noted that sensitive conversations were never discussed in public areas. Staff told us that, if necessary, they would use a quiet room to discuss confidential matters.

Patient understanding and involvement

- Patients told us they felt involved in their care. For example, they said they had been told what treatment options they had available to them and any risks or side effects had been pointed out.

- We observed patient families or their carers could accompany them into their consultation. This allowed patients to feel more at ease and meant they could have support when making decisions.
- The department undertook its own satisfaction survey using the information collected from public terminals in the department: 89% of patients say they would recommend the department to a friend or family member in July 2014. The response rate in June 2014 was 83%, and in May was 79%, compared to only 64% in March 2014. Staff said the poor response rate in March was due to the introduction of a new IT system which had caused major delays in clinics. Staff told us most of the issues with the new IT system had been addressed.

Emotional support

- Staff told us they would support patients who had received bad news by taking them to a quiet room and giving them the time to talk about their feelings.

Are outpatient and diagnostic imaging services responsive?

Inadequate



The responsiveness of the outpatients department at Charing Cross Hospital was inadequate. The hospital had not responded to the gradual increase in attendances to the department. The number of clinics had not increased in the last 12 months, despite an increase in patients. As a result, patients had to wait longer to get an initial appointment.

Doctors consistently turned up late for clinics without explanation and patients were waiting too long before they were seen in the clinics. Managers we spoke with were unable to set out the process by which they monitored performance and made improvement plans.

Too many clinics were cancelled by consultants at short notice and the hospital was not meeting its target of sending out appointment letters to patients within 10 working days of receiving the GP’s referral letter. There were many problems with the administration of appointments which led to unnecessary delays and inconvenience to patients.

Outpatients and diagnostic imaging

Service planning and delivery to meet the needs of local people

- Most staff told us there had been a gradual increase in number of patients attending the majority of clinics. Many staff felt this increase had not been effectively managed and, as a result, patients were waiting longer to get an initial appointment and were waiting longer in clinics to see the doctor or nursing practitioner.
- We noted no additional clinics had been organised to increase capacity to deal with the increased number of referrals. Staff told us this was because of the limited number of doctors.
- Managers we spoke with were unable to provide evidence to show how this increasing demand for outpatient services was being managed effectively or how they monitored performance.
- We were told by managers there was no system for ensuring the number of doctors and specialist nurse practitioners matched the needs of patients in any particular clinic. However, the current staff establishment meant longer waits for initial appointments and over-booking of clinics which lead to patients waiting longer to be seen in clinics.

Access and flow

- Most patients who attended the outpatients department were referred by their GP to the hospital. Other patients were referred from other hospitals or by other departments within the hospital. All referrals for outpatient appointments were registered by the central booking team who allocated appointments and sent out appointment letters to patients.
- We were told the trust's target was to provide the patient with an appointment letter within 10 working days of receiving their GP's referral letter. Staff told us that, on average, appointment letters were being sent to patients between three and five weeks after the GP referral letter had been received. However, we were told the trust was unable to provide us with any information to demonstrate the department's performance in this area as it was not monitored.
- Managers and staff told us GP referrals requiring urgent attention were identified and fast-tracked. During our inspection, we found the central booking team were starting to process urgent GP referral letters that had arrived on 1 September 2014.
- One patient told us, "The appointment system is haphazard. I got two letters with two different times for

- one appointment; I had to ring the secretary to find out what was going on". Another patient in the dermatology clinic told us, "I have had to wait three months for this appointment; my GP had to write two referral letters".
- Staff told us if clinics were delayed, information on the expected waiting times was displayed on a whiteboard in each of the clinics. In the six clinics we observed, we found patients were being informed by staff at regular intervals of any delays. We observed the whiteboard in the clinics was being kept up to date with the estimated delay times. Patients told us waiting times in clinics varied between a few minutes and more than two-and-a-half hours.
- While information relating to the time patients arrived and left the clinic was collected by the receptionist, the time the patient was called in for their consultation was not recorded. Therefore it was not possible for the department to monitor or accurately report patients' waiting times or to demonstrate that capacity did not meet demand.
- Information provided by the trust showed that the average waiting time to see a medical specialist for a first appointment, for non-urgent matters was nine weeks for most clinics. However, for surgery-related appointments, the waiting time was up to 13 weeks. Staff told us these delays were due to a shortage of available clinic appointments.
- The hospital performed worse than the England average for patients not attending appointments. For the financial year 2013/14, 10% of patients did not attend their outpatient appointment compared to the national average of 7%. Some staff told us that this was due to appointment letters not being sent out in a timely manner, therefore arriving after the appointment date. We were told some patients reported they had not received their appointment letter. The hospital cancelled 11% of the appointments, which was worse than the England average of 6%.
- Staff told us that too many clinics were cancelled by consultants at short notice. This meant inconvenience and delays for patients. Staff told us that ear, nose and throat and urology clinics had the highest number of short-notice cancellations. Most staff we spoke with, including managers, were not aware of the hospital's performance in relation to the cancellation of

Outpatients and diagnostic imaging

appointments. Those staff who were aware of the issue could not provide evidence to demonstrate that the underlying causes had been identified or that there were plans to improve performance.

- The hospital had a dedicated urgent cancer referral team who ensured all cancer referrals were managed effectively. Patients were able to see a consultant within the two-week target.
- Only three of the six clinics we observed on the day of our inspection had all the doctors present before the planned clinic start time. One clinic had no doctor at all for the first 30 minutes. Staff told us this was not an unusual occurrence and doctors were regularly late for clinics. The reasons for doctors' lateness were reported to be doctors being delayed in meetings, theatre or on ward rounds. However, as they often did not tell the clinic of these delays, staff could not inform patients.
- Staff told us most clinics usually overran slightly, by up to half an hour, and the longest delays of up to an hour were in neurology, plastic surgery and dermatology.
- The trust aimed to inform the patient's GP in writing of the outcome of their consultation in the outpatient department and any ongoing treatment that was required within five working days to ensure appropriate care and treatment was provided promptly. Staff were clear about this trust target. During our inspection we found this target was not always being met and GP letters were frequently delayed for more than 10 working days. We looked at 22 letters that were due to be sent out to GPs on the day of our inspection. We found that 11 (50%) were not being sent out within the target time. The oldest letter was for a clinic that occurred 21 days previously.
- Staff we spoke with, including the medical secretaries who were responsible for sending the GP letters from the patient's consultant, were clear about the process for preparing and sending these letters. However, staff and managers we spoke with were unable to confirm how the department was performing against the trust's five-working-day target. They could not provide us with evidence to demonstrate this target was being met as information had not been collected on the department's performance.

Meeting people's individual needs

- Staff told us they had ready access to a translation service for those patients who did not speak English as their first language. Written information was available in different languages on request.
- All clinics had been fitted with induction loops to support people with hearing needs.
- We saw that a young patient who had arrived in the department in a wheelchair was identified by the floor walker as needing additional support. The patient was taken to the clinic and introduced to the receptionist who took over responsibility for assisting them. We spoke to the patient before they left and they told us, "They have been great, I know I have to wait a while, but they have been as quick as they can".
- There was a range of written information available for patients in the outpatient waiting areas. Some of these leaflets had been produced by the trust and others had been produced by external agencies such as the Royal Colleges.
- Patients with queries about the date or time of their appointment were given a central telephone number to contact which aimed to effectively resolve these issues. However, patients told us they sometimes experienced difficulties when contacting specific medical secretaries and the central booking office. These difficulties included long waiting times for the telephone to be answered as well as getting through to the correct person.
- Staff told us they had been trained to identify people living with dementia and how to provide them with additional support. For example, by giving people more time to talk and making sure patients understood the details of their treatment.

Learning from complaints and concerns

- Information on how to make a complaint was easily available in the waiting areas.
- We were told informal complaints were managed by the outpatient matron or nurse in charge and resolved if possible at this stage. If they were unable to resolve the complaint satisfactorily, the patient or relative were directed to the Patient Advice and Liaison Service (PALS) who would help them to make a formal complaint.

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- The staff in PALS told us the outpatients department at Charing Cross Hospital had many more issues raised by patients than the other two acute hospitals in the trust. The main issue raised by patients was the amount of time they had to wait to see the doctor.

Are outpatient and diagnostic imaging services well-led?

Inadequate



There was no identified individual or group who had overall responsibility for the governance of the outpatients department. This resulted in some quality and risk issues not being managed effectively. Staff told us they felt supported by their local clinical managers but did not think the senior managers understood how things worked on the frontline. The trust's vision and values were not understood or fully supported by all staff in the department. Some staff told us it was unclear how changes at trust level affected them in their role.

Staff met with their local managers to discuss performance and concerns on a regular informal basis, but there were no regular department meetings at which the staff from outpatients, central booking and medical secretaries met to discuss performance and other issues of common concern.

Vision and strategy for this service

- Most staff told us that, over the last six months, they had a clearer vision of the trust's direction. However, some staff told us it was unclear how changes at trust level affected them in their role.
- Staff told us there had been a number of trust-wide briefing sessions about the general future direction of the trust. Most of the staff we spoke with had been to these briefings.
- Staff said that, although they had monthly meetings in the department, this did not provide information on future developments affecting their area.

Governance, risk management and quality measurement

- There was no identified individual or group who had overall responsibility for the governance of the outpatients department. Responsibility was shared between staff in the clinical specialties and the

outpatients management team. This resulted in some quality and risk issues not being managed effectively – for example, the late attendance of doctors to clinics. We were not provided with any evidence of examples of quality improvement programmes or action plans to address identified issues.

- There was a lack of performance information relating to areas such as management of appointment letters, waiting times in clinics and communication with GPs following an outpatient consultation. Non-clinical managers we spoke with did not demonstrate they had knowledge and understanding of the performance in their areas of responsibility.
- Staff were not provided with information regarding their clinics' performance and were unaware of the key performance indicators set for their clinics.
- There were no regular department meetings at which the staff from outpatients, central booking and medical secretaries met to discuss performance and other issues of common concern.

Leadership of service

- The nurse in charge of the department held a briefing each morning before any patients arrived. We were told the purpose of this meeting was to identify any patients who might need support, allocate tasks to staff and deal with any specific issues that needed addressing. In addition, the nurse in charge also held a formal monthly meeting with all nursing staff to discuss performance.
- The outpatients department was dispersed within the structure of the hospital management. Many clinics were coordinated within the general outpatients department but others were managed by the clinical specialities. This meant staff were not clear who their respective senior leaders were.
- Staff working in each department told us they felt able to discuss a range of issues with their line manager and felt able to contribute to the running of the department. However, they said the senior management team was not visible and "did not understand staff's operational issues".

Culture within the service

- Clinic staff we spoke with were patient-focused and aimed to provide a good service for patients.
- Staff said there was an open culture in which they were encouraged by their line managers to raise and report concerns.

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- We observed staff working well as a team and spoke about supporting and helping each other as required to ensure clinics ran effectively.

Public and staff engagement

- Patients attending outpatients clinics were able to provide feedback by using touch-screen terminals available in waiting areas. This feedback was analysed, shared among staff and posted on the wall for patients to see. However, although this information was collected and analysed in terms of the numbers of people who answered positively to questions, there was

no detailed assessment of public dissatisfaction which would identify possible areas for improvement. For example, there was no information about what it was that made people unhappy with the service.

Innovation, improvement and sustainability

- Patients attending clinics were able to use self-check-in terminals to book into clinics, which reduced the time spent waiting at the reception desk. To assist and support patients with this process there was a floor walker on duty at all times.

Outstanding practice and areas for improvement

Outstanding practice

- Outstanding leadership in the A&E department contributing to high staff morale and efficient, fail safe systems for patients.

Areas for improvement

Action the hospital **MUST** take to improve

- Correct the problems associated with the administration of appointments which was leading to unnecessary delays and inconvenience to patients.
- Address the high vacancy rates for nursing staff and healthcare assistants in some medical wards, and the level of medical staffing out of hours for the intensive care unit (ICU) and level 2 beds.

Action the hospital **SHOULD** take to improve

- Take sufficient steps to ensure the 'Five steps to safer surgery' checklist was embedded in practice at Charing Cross Hospital.
- Ensure that all patients who undergo non-urgent emergency surgery are not without food and fluids for excessively long periods.
- Increase the capacity in the outpatients department to address the increased demand and adequately respond to people's needs.

- Assign sole responsibility for the outpatients department to one division so that quality and risk issues could be managed more effectively.
- Ensure learning from investigations of patient falls and pressure ulcers is proactively shared trust-wide.
- Meet its target of sending out appointment letters to patients within 10 working days of receiving the GPs referral letter.
- Ensure outpatient letters to GPs occur within its target time of 10 days following clinics.
- Reduce the backlog of patients who are awaiting elective surgery.
- Increase capacity to ensure patients admitted to the surgical services can be seen promptly and receive the right level of care.
- Avoid cancelling clinics were cancelled at short notice.
- Minimise number of out-of-hours transfers and discharges from the medical wards.

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

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

Regulation

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

People who use services were not protected against the risks of care or treatment that is inappropriate or unsafe because the problems associated with the administration of appointments for the outpatients department were leading to unnecessary delays and inconvenience to patients.

Regulation 9 (1) (a)(b)(i)

Regulated activity

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

Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

People who use services were not protected against the risks of care or treatment that is inappropriate or unsafe because there were not sufficient numbers of nursing staff and healthcare assistants in some medical wards; and insufficient medical staff for out of hours ICU and level two beds.

Regulation 22