London North West Healthcare NHS Trust

Quality Report

Trust Headquarters
Northwick Park Hospital
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unnanounced visits 3 - 7 November 2015
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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

London North West Healthcare NHS Trust is one of the largest integrated care trusts in the country, bringing together hospital and community services across Brent, Ealing and Harrow. Established on 1 October 2014 from the merger of North West London NHS Trust and Ealing Hospitals NHS Trust, and employing more than 8,000 staff it serves a diverse population of approximately 850,000.

The trust runs Northwick Park Hospital, St Mark's Hospital, Harrow; Central Middlesex Hospital in Park Royal and Ealing Hospital in Southall. It also runs 4 community hospitals – Clayponds Rehabilitation Hospital, Meadow House Hospital, Denham unit and Willesden Centre - in addition to providing community health services in the London Boroughs of Brent, Ealing and Harrow.

At the end of the financial year 2014-15 the trust had a deficit of £55.9 million.

We carried out this inspection as part of our comprehensive acute hospital inspection programme for combined acute hospital and community health based trusts. We inspected Northwick Park Hospital, Ealing Hospital and the following community health services: community services for adults; community services for children, young people and families; community inpatient services; community services for end of life care and community dental services.

The announced part of the inspection took place between 19-23 October 2015 and there were further unannounced inspections which took place between 3-7 November 2015.

Overall we rated this trust as requires improvement. We rated acute end of life services as good. We rated the following acute services provided by the trust as requires improvement: Urgent and emergency care, medical care including care of the elderly, surgery, critical care, maternity and gynaecology, acute services for children and outpatients and diagnostic imaging.

We rated the following community services as good: services for children, young people and families, services for adults, and end of life care. We rated the following community services as requires improvement: community inpatient services and community dental services.

We rated caring at the trust as good, but safety, effective, responsive and well-led as requires improvement.

Our key findings were as follows:

- The merger of the trust had been protracted and subject to delay. This had had a negative effect on performance and leadership.
- We saw overall disappointing progress in merging systems and processes at the trust. To most intents and purposes Ealing and Northwick Park appeared to be operating as separate entities and community health services appeared disengaged from the rest of the trust.
- There appeared to be substantial duplication of support functions at both main sites. There appeared to have been lack of control over spend of administrative, non-staff, and nursing staffing budgets with little rationale over nursing numbers on wards.
- A new chief executive had recently been appointed earlier in 2015. She was in the process of building a new executive team and by the time of our inspection only one member of the previous substantive executive team was in post. This meant that the new executive team were in the process of getting to grips with their respective functions.
- All staff working at the hospital were dedicated, caring and supportive of each other within their ward and locality. There was a high degree of anxiety and uncertainty borne out of the merger and also fears of service removal and potential job losses particularly at Ealing Hospital.

  • There appeared to be a lack of firm information provided to staff about the effects of Shaping a Healthier Future - to reconfigure services in north west London - despite the chief executive holding regular briefing session. This added to staff anxieties.

- We saw several areas of good practice or progress including:

Summary of findings

- a newly opened emergency department at Northwick Park

- a good service overall for end of life care particularly at Ealing and in the community health service.
- a refurbished and child friendly ward for children's care called Jack's Place.
- caring attitudes, dedication and good multi-disciplinary teamwork of clinical staff.
- good partnership working between urgent and emergency care staff and London Ambulance staff.
- good induction training for junior doctors.
- research projects into falls bundles, stroke trials and good cross site working in research.
- Staff told us there were good opportunities for training and career development.
- We found the specialist palliative care team (SPCT) to be passionate about ensuring patients and people close to them received safe, effective and good quality care in a timely manner.
- The play specialists in services for children demonstrated how they could make a difference to the service and its environment in meeting the needs of the children and young people. This included an outstanding diversional therapy approach for children and young people, which was led by the play specialist and school tutor.
- evidence of good antibiotic stewardship, particularly at Ealing pharmacy, with regular reviews of need; and the roll out of drug cabinets across certain parts of the trust with secure finger print access.
- patient satisfaction data collected by iPAD in one pharmacy location
- an increase in pharmacy cover at one community unit (Denham) enabling reduced medicines related risks.
- The availability and input of dedicated psychologists as part of the multidisciplinary team at the Willesden Centre for Health and Care provided patients with improved long term outcomes.
- The virtual ward operating in the Harrow community, with input from clinicians based at Northwick Park Hospital, supported patients who have long term chronic conditions to stay in their own homes and reduce hospital admissions.

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

- There was limited sparse medical cover on eHDU out of hours and at weekends, which meant there was frequently no doctor immediately available on the unit. Consultants responsible for eHDU and Dryden HDU were not intensivists and processes for escalating surgical patients were unclear. Additionally, less than the recommended proportion of eHDU nurses had critical care qualifications.
- There was a lack of expert support from consultant radiologists at weekends, which impacted on the accuracy of clinical diagnosis being achieved. Risks related to patient safety and service delivery had not always been identified and agreed timelines for resolution had not always been identified. This led to scans being reported by specialist registrars (SpR's) and amended by consultants on Mondays. They reported an apparent 25% amendment rate, with missed pathologies.
- Surgical staff were not always reporting incidents. Consultants and other surgical staff told us they did not routinely complete incident reports for issues or concerns as the forms were said to be "too laborious" and nothing was done to change the problems highlighted.
- Access to services and patient flow through the ED at Northwick Park to wards in the hospital was poor and patients experienced long waits in the HDU and assessment unit areas.
- The performance dashboards for ED showed that compliance with achieving the mandatory targets, including the 4 hour treatment target, had been poor over the previous 12 months.
- The emergency department participated and performed poorly in the College of Emergency Medicine audits on pain relief, renal colic, fractured neck of femur and consultant sign-off; and there were no clear action plans drawn up by the department indicating what actions were taken as a result of the audits.
- Compliance with safeguarding training was poor particularly among medical and dental staff.
- The trust target was to have 95% of staff having completed mandatory training. Trust data, as of March 2014 – July 2015, showed compliance with the target was poor in many areas.

Summary of findings

- We saw examples of poor infection control practice such as linen left on a bin when a nurse was putting gloves on, staff wearing nose rings and hooped earrings that were not covered and name badges that were made of paper.
- There was a poor environment on the stroke wards at Northwick Park Hospital.
- There were poor handovers between ED and the wards at Northwick Park with MRSA screening and medicines management not always clear or complete in the handovers.
- Nutrition and hydration was poorly managed on Northwick Park medical wards with poor assessments, choice of food and support for those that needed it.
- In surgery, several groups of patients had no formally defined pathway, which impacted on their safety.
- The National Bowel Cancer Audit for 2014 indicated that data completeness for patients having major surgery was poor at 30%, compared with an England average of 87%.
- There was a lack of formal escalation process for surgical patients who deteriorated on eHDU aside from the support provided by the outreach team.
- Handovers to the consultant taking over care of eHDU patients on a Monday morning was completed by the weekend on call anaesthetic registrar rather than a consultant to consultant handover. Staff highlighted this as a concern as there was a risk important information could be missed.
- In maternity and gynaecology, there were safety concerns related to midwife shortages, not having safety thermometers on display and some staff reporting that they did not get feedback after reporting incidents. Staff raised concerns about one midwife covering the triage and observation areas at same time during times of pressure.
- We were concerned that some of the risks we identified were not on the risk register, such as the room used for bereaved women on the delivery suite at Northwick Park Hospital with a lack of sound proofing from the ward.
- Staff on wards outside of the end of life team had a poor understanding of end of life care and the trust LDLCA - Last days of life care agreement. Concern was raised that doctors and nurses on the wards did not recognise deteriorating and dying patients.
- Signage for outpatient clinics was in some cases poor and or stopped short of providing clear directions for patients.
- In outpatients and diagnostic imaging, poor patient experience was due to overbooking clinics, lack of capacity in outpatients and lack of availability of medical records in time for clinics.
- In OPD, we were concerned incidents were not always appropriately recognised, escalated or investigated and lessons learned were not widely shared.
  - The pre-inspection information identified some concerns around consultant cover in haematology. Some of the facilities were not suitable to meet the needs of patients, for example, the haematology day care service.
  - At Ealing ED we had some concerns around the care and treatment of children. There were insufficient children's nurses employed to ensure they were consistently available at all times. Not all adult-trained staff had been trained in paediatric life support.
  - There were some aspects of poor morale of staff on the medical wards at Ealing.
  - There were some concerns with cleanliness and the state of repair or servicing of equipment and fixtures on medical wards at Ealing.
  - Audits showed hand hygiene was a concern with some wards either not submitting audits or scoring less than 90%.
- All types of therapy visits on wards were unscheduled meaning patients could miss their therapy if they were away from their bed or in pain.
- We were concerned at the lack of provision for dementia care and inconsistent assessment of patients failing to direct them to a dementia friendly wards at Ealing. However, patients living with dementia were not specifically triaged to be admitted to this ward and some aspects of the ward were not dementia friendly.
- In surgery at Ealing there was inadequate stock of some "bread and butter" items of equipment, such as endoscopic gastro-intestinal cartridges.Sets came back from the decontamination unit incomplete.
- At Ealing OPD, the outpatients risk register identified five issues of concern including lack of capacity,

Summary of findings

temperature in the women's clinic environment, lack of availability of complete medical records, overbooking clinics and absence of a dedicated plaster sink in the plaster room.
- Trust wide there were temperature control issues across sites in rooms where medicines are stored.
- The trust was not compliant with Fit and Proper Persons regulations requirements.
- The above list is not exhaustive and the trust should address these and the rest of the issues outlined in our reports in its action plan.

Importantly, the trust must:

- provide expert support from consultant radiologists at weekends.
- ensure effective processes for reporting, investigating and learning from incidents, and ensure all staff always report incidents.
- provide sufficient trained and experienced medical and nursing cover on eHDU at all times including out of hours and at weekends to ensure immediate availability on the unit.
- We issued the trust with a Section 29 (A) warning notice in relation to the three " must do" items listed immediately above requiring substantial improvements.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to London North West Healthcare NHS Trust

London North West Healthcare NHS Trust is one of the largest integrated care trusts in the country, bringing together hospital and community services across Brent, Ealing and Harrow. Established on 1 October 2014 from the merger of North West London NHS Trust and Ealing Hospitals NHS Trust, and employing more than 8,000 staff it serves a diverse population of approximately 850,000.

The trust runs Northwick Park Hospital, St Mark's Hospital, Harrow; Central Middlesex Hospital in Park Royal and Ealing Hospital in Southall. It also runs 4 community hospitals – Clayponds Rehabilitation Hospital, Meadow House Hospital, Denham unit and Willesden Centre - in addition to providing community health services in the London Boroughs of Brent, Ealing and Harrow.

At the end of the financial year 2014-15 the trust had a deficit of £55.9 million.

The trust currently does not have foundation trust status.

The trust serves an ethnically diverse population in all three boroughs: The health of people in Brent is varied compared with the England average. Deprivation is higher than average and about 24.8% (16,200) children live in poverty. Life expectancy for both men and women is higher than the England average. It ranks 35th most deprived of 326 local authorities in the country. The health of people in Ealing is varied compared with the England average. Deprivation is higher than average and about 21.6% (15,300) children live in poverty. It ranks 80th most deprived of 326 local authorities in the country. The health of people in Harrow is generally better than the England average. Deprivation is lower than average, however about 17.0% (8,000) children live in poverty. It ranks 194th most deprived of 326 local authorities in the country. Life expectancy for both men and women is higher than the England average in all three Local Authorities.

Activity, bed and financial data for the trust is as follows:

• **Beds**: 1,240

– 1,112 General and acute

– 69 Maternity

– 27 Critical care

• **Staff**: 7,563

– 1,393 Medical

– 3,462 Nursing

– 2,708 Other (excluding admin & estates)

• **Revenue**: £679,660

• **Full Cost:** £748,872

• **Surplus (deficit):** (-£69,212)

Activity summary (Acute)

Activity type - 2014-15

Inpatient admissions - 163,864

Outpatient (total attendances) - 683,589

Accident & Emergency(attendances) - 126,131

We inspected Northwick Park Hospital, Ealing Hospital, and the trust's community health services including in-patient facilities. We did not inspect Central Middlesex Hospital on a risk basis as this had been inspected in 2014 prior to the trust merger and had been rated Good. This inspection was part of our planned comprehensive inspection programme and we inspected all core services at the locations inspected.

Our inspection team

Our inspection team was led by:

Chair: Dr Richard Quirk, Medical Director Sussex Community NHS Trust.

Summary of findings

Head of Hospital Inspection: Nicola Wise (Robert Throw supporting) CQC.

The inspection team consisted of CQC managers and inspectors plus specialist clinical and non-clinical advisers including: senior NHS manager, A&E doctor, A&E nurse, critical care doctor, child safeguarding nurse, end of life care nurse, maternity doctor, midwife, general medicine doctor, general medicine nurse, outpatients doctor, outpatients nurse, paediatric doctor, paediatric nurse, surgery doctor, adult community nurse, community midwife, chiropodist/podiatrist, adult community doctor, adult physiotherapist, surgery nurse, occupational therapist, junior doctor, student nurse, community children's nurse, sexual health therapist, experts by experience/patient representatives.

How we carried out this inspection

To get to the heart of patients' experience of care in this acute hospital and community health setting we always as the following five questions of every service and provider:

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

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the trust. These included local clinical commissioning groups, NHS England, Health Education England, NHS Trust Development Authority (now NHS improvement), General Medical Council, the Nursing and Midwifery Council, Royal Colleges and local Healthwatch.

We held a public listening event with the intention of listening to the views of patients, their families and carers as well as members of the public about the services provided by the trust.

We spoke with patients and their families and carers and members of staff from all the ward and community health areas. We reviewed records of personal care and treatment as well as trust policies and guidelines. We held focus groups of different clinical and non-clinical staff grades to gain their views. Similarly we held a focus group for black and ethnic minority staff.

In addition to the announced inspection which took place between 19 - 23 October 2015, we carried out unannounced visits between 3 - 7 November 2015.

What people who use the trust's services say

Friends and Family Test (FFT)

The latest FFT was still collected separately by the former trusts before the latest merger. Both had an overall rate recommending or highly recommending services close to or slightly above the England average.

Patient Led Assessment of the Care Environment (PLACE)

The trust came out poorly in the PLACE assessments for Food and Privacy, Dignity and Wellbeing when compared to the England average.

2014 NHS Staff Survey

The trust returned 4 positive findings and 7 negative findings in the 2014 NHS staff survey.

The 'Negatives' in 2014 related to:

- Percentage of staff appraised in the last 12 months.
- Percentage of staff working extra hours.
- Percentage believing the trust provides equal opportunities for career progression and promotion.
- Percentage of staff experiencing discrimination at work.
- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public.
- Percentage of staff experiencing harassment, bullying or abuse from staff.

Summary of findings

- Percentage of staff experiencing physical violence from staff.

Royal College of Nursing

The Royal College of Nursing (RCN) reported that the trust appeared to have failed to achieve a planned £15 million saving from the trust merger; a very high spend for bank and agency staff; a lack of communication and engagement with staff and public over changes, and some unresolved issues with trade unions/staff side.

NHS TDA

NHS TDA reported issues in relation to finance (£55.9 million year end deficit) and performance issues, including referral to treatment breaches, one twelve hour trolley wait for a patient in A&E and cancer treatment waits. They reported some concern with the trust breaching its hospital acquired infection (C.diff) target variance from plan since June 2015 and the trust being marginally below standard for harm free care at 94%.

GMC 2015 National Trainee Survey (NTS)

The GMC reported seven patient safety comments raised through the 2015 GMC NTS. There were a variety of themes as follows: Gastroenterology (poor record keeping re handover), Geriatric Medicine (inadequate nursing skills out of hours), Obstetrics & Gynaecology (clinical supervision and staff shortages), Paediatrics (long working hours), Public Health Medicine (poor interdepartmental communication) and Trauma & Orthopaedic Surgery (staff shortages)

Four trainees reported experiencing undermining, belittling or intimidating behaviour. The specialities involved were Paediatrics, Obstetrics & Gynaecology and Acute Internal Medicine.

The trust has taken action to resolve these issues. An action plan is in place and is being monitored.

NHS England London Region

- Referral to treatment (RTT): At Northwick Park, following a remodelling analysis, additional bed capacity requirements have now been agreed with CCG commissioners. This work is due to complete in December 2015.NHSE reported concerns around recruitment (workforce capacity), given the difficulty of the trust to recruit to existing medical and nursing vacancies across the organisation.
- Hospital Standard Mortality rate (HSMR): NHSE noted that LNWHT's HSMR is increasing. An external review is currently being undertaken.
- RISK: NHSE were concerned about a low level of risk assessment completion, low level of serious incident reporting (and delays in process), DOLs recording and VTE assessment. Additionally, in March 2014/15 LNWHT recorded an outlier position on their hospital induced VTE.
- NHS PEER REVIEW 2015: An external visit to the Haematology MDT and SIHMDS service at Northwick Park Hospital identified that:
- There was no cover provided for the clinical oncologist whose attendance at the MDT is below the required minimum.
- The Trust did not fulfil the criteria to be providing a SIHMDS as it did not meet the required population. There was no evidence to show that when samples were identified locally as demonstrating a haematological malignancy these samples were sent directly to the SIHMDS for further investigation. Many investigations were still being undertaken locally.
- Due to the lack of a single IT system and one SIHMDS service a single electronic integrated report was not available.
- It should be noted that the Trust (in July 2015) have provided a response and will be resolving these issues.
- **Brent Healthwatch:**
- Brent Healthwatch reported a problem with duplicate tests between the trust and local GPs, for example blood tests already undertaken being repeated at the trust.
- There appeared to be no leave or absence cover for a learning disability supporting nurse at Norhwick Park.
- The trust cancer unit was praised.
- The CCG raised an issue over patient treatment waits at the trust eye unit.
  - **Harrow Healthwatch**
- Felt confident in the trust going forward, particular at senior level with a new leadership team.
- Harrow CCG raised issues with capacity in A&E but moving in right direction. There were complex pressures due to local demographics with some local people not using GP practices as their first point of contact.
  - **Brent and Harrow CCG**
- Concerns were reported as follows:

Summary of findings

- Low level of Serious Incident Reporting / Investigation
- Risk Management
- Pressure Ulcer management
- Surgical safety concerns
- Closure of Ealing Hospital Maternity Services and transition management.
- Non elective caesarean rates for M3
- Workforce pressures

Facts and data about this trust

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Activity type

Inpatient admissions - 163,864

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Safe

• Rates of pressure ulcers, urinary tract infections and falls recorded by the Patient Safety Thermometer have been variable with no discernible trends. There were 32 pressure ulcers recorded in May 2015.

• Serious incidents: 207 were for Northwick Park and 148 for Ealing between Aug 2014 and Jul 2015. In the same period there were 122 ambulance delays and 124 pressure ulcers meeting serious incident (SI) reporting criteria.

• Incidents: 31 deaths were reported to the NRLS. Overall there were fewer NRLS incidents per 100 admissions than the England average for the same period.

• At Northwick Park, the proportion of junior doctors and consultants is similar to the England average. At Ealing the proportion of junior doctors is higher and the proportion of consultants is lower than the England average.?

• Infection rates for C. diff and MSSA have been higher since the trust merger. MRSA rates were variable between 0 and 2 in any given month with no discernible trends.

• There were four never events reported between August 2014 and July 2015. 3 in Northwick Park(Medicine x2 and Surgery x1). There was also one in Ealing in the Children's core service.

Never events details: Medicine: Aug 2014 (2014/28410) – misplace NG tube, patient died. May 2015 (2015/17992) – transfusion incident, wrong blood given. Surgery: Dec 2014 (2014/41155) – wrong site surgery, on finger.

NRLS incidents: There were fewer NRLS incidents per 100 admissions than the England average for the same period.

Bank and agency staff levels are more than double the England average.

The CQC intelligence monitoring report for May 2015 showed elevated risks for:

- Nursing staff (low) in proportion to occupied beds (Jan to Dec 14)

- Other clinical staff (low) in proportion to occupied beds (Jan to Dec 14).

Effective:?

Despite NHSE's observation of increased HSMR mortality, the CQC Hospital IM report May 2015 showed no evidence of elevated risk.

Caring:?

Summary of findings

Prior to the merger both former trusts' performance in the Friends and Family Test was consistently below the England average. It has subsequently improved to a level above the England Average.?

In the Cancer Patient Experience Survey the Trust was in the bottom 20% of trusts for 16 out of 34 indicators.

Patient Led Assessments of the Care Environment: There was a mixed performance compared with the England average for all four measures. There was an elevated risk for food (Jan to Jun 14) in CQC's Hospital Intelligent Monitoring (IM) report May 2015. (This appeared to relate to Ealing, where 2014 Privacy, dignity and wellbeing score had also fallen).

The Trust scored "about the same" as other trusts in 7 and were in the "worst performing trusts" in 5 indicators in the 2014 in-patient survey.

Responsive?

In CQC's Hospital Intelligent Monitoring report for May 2015, the Trust flagged as an elevated risk indicator for A&E waiting times more than 4 hours (Oct to Dec 14).

Well-led?

The sickness absence rates at Ealing have been consistently below the England average.?

The sickness absence rates at Northwick Park have been very similar to the England average.

There was mixed performance in the NHS Staff Survey 2015, with 4 positive and 7 negative findings. 19 findings were within expectation for a trust of this size.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Overall safety at the trust required improvement. Comments are trust wide unless specific locations are identified. There was a lack of both permanent medical and nursing staff and although this was improving, we were concerned a high number of recently recruited staff would soon move to the new AMU at Northwick Park which would then increase the vacancy rate again. In Ealing A&E we had some concerns around the care and treatment of children. There were insufficient children's nurses employed to ensure they were consistently availability at all times. Not all adult-trained staff had received training in paediatric life support. The department did not have enough doctors and nurses to keep patients safe at all times. At Northwick Park we saw that staffing levels were not sufficient in the children's ED to provide safe care. However, other nursing staffing levels were set to meet patients' needs at all times. Medical services safety trust wide required improvement. Nurse staffing levels did not always meet the acuity and dependency of patients, with a high use of agency staff and a variable amount of vacancies. Medical staffing was mostly appropriate although there was some high use of junior doctors and a lack of senior staff overnight on site presence. At the time of our inspection the newly appointed director of nursing was reviewing staffing levels against acuity tools to develop a rationale and to plan future staffing. We rated safety for surgery at Northwick Park as inadequate. There was under reporting of incidents and a lack of learning from those that were reported. Not all actions associated with the WHO surgical safety checklist were being completed. There was a lack of expert support from consultant radiologists at weekends, which impacted on the accuracy of clinical diagnosis being achieved. Risks related to patient safety and service delivery had not always been identified and agreed timelines for resolution had not always been identified.They reported an apparent 25% amendment rate, with missed pathologies and provided examples to us. Nursing staff shortages in one ward in particular impacted on safety. In surgery at Ealing the World Health Organization (WHO) Surgical Safety Checklist had not been implemented in the endoscopy	**Requires improvement** 

service. Surgical instruments were not always readily available. The recovery area did not have sufficient capacity to enable all patients to be recovered following their surgery. The environment was not suitably planned and arranged for the needs of children.

Safety within the critical care unit at Ealing was good and people were protected from avoidable harm and abuse. There were thorough patient risk assessments completed at suitable intervals and staff responded appropriately to changes in risks. Patient safety thermometer results were good. Staff demonstrated appropriate knowledge and understanding of safeguarding principles, and we observed embedded systems to keep people safe from abuse.

However at Northwick Park, safety across critical care required improvement as there was an increased risk of patient harm. There was limited sparse medical cover on eHDU out of hours and at weekends, which meant there was frequently no doctor immediately available on the unit. Consultants responsible for eHDU and Dryden HDU were not intensivists and processes for escalating surgical patients were unclear. Additionally, less than the recommended proportion of eHDU nurses had critical care qualifications.

Provision of pharmacy staff did not meet recommended levels and no pharmacist was in place for patients cared for in the overnight intensive recovery unit (OIR).

We found that the current safety arrangements in maternity in the trust requires improvement. NHS Safety Thermometer information was not displayed in public areas throughout the service and we were not given their results.

We found the early pregnancy unit at Northwick Park Hospital looked untidy and not very clean.

Safety of the children's service at Ealing required improvement. Although the safeguarding children's procedures were embedded and robust, other policies and procedures required review and updating. The management of medicines was seen on the risk register with frequent comments about changes in practice identified, but we could not be assured that lessons were learned and changes in practice had taken place. There were notable staffing shortages for registered staff across the service with excessive use of agency staff in July and August 2015.

Safety of the children's service at Northwick Park required improvement because, although the safeguarding children's procedures were embedded and robust, additional policies and procedures reviewed as hardcopies in folders for staff were out of date.

Summary of findings

Safety across the Ealing hospital and Northwick Park hospital sites for end of life care was good. Staff were able to communicate their responsibility and role in early identification of any concerns. They know whom the safeguarding lead for the trust was and where to get guidance should they require it.

The Specialist Palliative Care Team were highly skilled in supporting patients with complex health issues and requiring palliative or EOL support.

Overall we found the safety of outpatient and diagnostic services was good at Ealing Hospital. We found staff were aware of how incidents were escalated; there was information available about the Duty of Candour for patients and staff. There were no never events identified within outpatients and diagnostic services at Ealing Hospital. We saw evidence of a robust serious incident investigation and learning objectives were set following the incident.

However, overall the safety of outpatient services at Northwick Park Hospital required improvement because systems and process were not robust enough to manage the risks to people who use services. There were regular shortages of planned staffing levels.

Safety across community health services for end of life care was good. Openness and transparency about safety was encouraged. Staff fully understood their responsibility to raise their concerns and report incidents and near misses. However we found some staff concerns such as missed appointments had not been reported as they should have been.

Incidents

At Northwick Park Hospital and Ealing Hospital we found that there was a system in place for incident reporting, however some staff told us that they did not always get feedback.

Incidents were investigated adequately; a root cause analysis was completed and learning points and actions identified. However some staff reported they did not always know the outcome or improvements made as a result of the incident and did not routinely know of issues raised by other areas or departments in the trust. Therefore it was difficult to identify risks and trends and improve consistency in practice across the whole of the trust's community services.

However, despite the availability of effective processes for reporting, investigating and learning from incidents, surgical staff were not always reporting incidents. Consultants and other surgical staff at

Summary of findings

Northwick Park told us they did not routinely complete incident reports for issues or concerns as the forms were said to be "too laborious" and nothing was done to change the problems highlighted.

Safety Thermometer

Safety thermometer results were displayed in most of the wards in medical care, surgery and critical care areas we visited, including staffing levels, pressure ulcers, urinary tract infections, VTE assessments, and falls. Results were variable between wards. Across the trust, pressure ulcers, UTIs, and falls were around the national average. Audits for care bundles relating to patient harms were mostly 100% or just below 100% and we found very few of these care bundles were not completed. Falls were a particular concern on the care of the elderly wards.

We found that NHS Safety Thermometer results were not visible to patients and visitors throughout the maternity service. We requested the results of the safety thermometer for the service. However, this was not provided.

Cleanliness, infection control and hygiene

We found the trust had systems in place to prevent and protect people from healthcare associated infections. The trust had an infection prevention and control policy (IPC) and all staff received training. The staff we spoke with had a good understanding of IPC practices and we observed staff following IPC measures when visiting the patients on the wards. Staff were aware of patients' reduced immune systems and the measure they should take in order not to compromise their health through poor infection control.

However we did not see evidence of standard trust wide implementation and engagement. The trust IPC team is visible and visits all locations. However uncertainties within the trust have stalled progress and there are several interim posts in the IPC team.

There had been some acquired Clostridium difficile, but they were in different wards and there was no identifiable trend. However although Methilicin resistant staphylocous aureus audits showed mostly 100% or near compliance, we found some patient notes showed swabs had been taken but no result had been recorded. C diff and MRSA rates are both above trajectory.

Most of the clinical areas we visited were visibly clean, and all the waiting areas and toilet facilities we inspected were clean.

Summary of findings

Cleaning schedules and records were available in all wards and clinical staff told us that cleaners were available throughout the day to clean if necessary.

While we saw staff observed bare below the elbow on wards some staff were not adhering to dress and jewellery IPC protocols.

Environment and Equipment

The emergency department at Northwick Park was rebuilt and opened in November 2014. The major's area, known as the High Dependency Unit (HDU), had 16 enclosed cubicles, the majority of which were not visible to the nurses or the doctors when seated at the nurse's stations. Direct observation was further limited because of the location of the cubicles; however, there were nurses assigned to cubicles to mitigate this. There was a central monitoring, observation and working area in the HDU. There were 26 cubicles in the assessment area. The department had a wide range of specialist equipment, which was clean and well maintained.

However, at Ealing ED the supply of suitable monitoring equipment was insufficient within the department. We noted that only one monitored bed was available.

Staff told us there was not normally an issue with lack of equipment and they could borrow from neighbouring wards if necessary. However, some staff told us equipment that required repair or replacement could take some time unless it was urgent.

Surgical wards ranged in size and layout but were noted to be set out in a manner which ensured people were safe.

Surgical equipment including resuscitation and anaesthetic equipment was noted to be readily available and was fit for purpose. Most equipment had been checked in line with professional guidance.

The endoscopy department at Ealing had not achieved Joint Advisory Group (JAG) accreditation as a result of a number of factors, for example, not being able to meet ventilation requirements in the endoscope decontamination room.

The critical care environment at both hospitals was not compliant with HBN0402 building notes and infection prevention and control measures, including use and disposal of personal protective equipment and barrier nursing measures were not consistently adhered to. Some patient rooms were not large enough to comply with HBN0402 guidelines.

In maternity, we looked at various pieces of equipment throughout the service and found that they were properly maintained. We saw they had a Portable Appliance Test (PAT) or a maintenance service in the past year. This included baby scales, a blood pressure machine and a neonatal resuscitaire.

Resuscitation equipment for adults and babies was available throughout the service and was being maintained appropriately.

There were Cardiotocograph (CTG) machines to allow for electronic monitoring of the fetal heart during pregnancy and labour available throughout the maternity service.

Where the environment in children's services had recently been refurbished (such as in Jack's Place) it looked clean and fresh. The environment within the neo natal unit (NICU) had not been refurbished for several years.

Resuscitation equipment was available in cardiology, outpatients and orthopaedic clinics. We saw evidence they were regularly inspected by staff and records of these checks were consistently made. However, we were told about frequent equipment failures resulting in delays completing and reporting diagnostic tests including CT scans in some cases.

Medicines

Medicines were generally stored, managed, administered and recorded safely and appropriately. Training data for the department showed that nursing staff had received training in medicines management.

We checked the process for obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal of medicines on wards and in theatres. The arrangements for managing medicines and medical gases ensured people were kept safe. Medicines were stored safely in lockable cabinets, which were secured to a wall when not in use. Fridge temperatures for storage of temperature controlled medicines in most cases had been carried out and action taken when the range was outside safe levels.

In surgery, medicines were prescribed, stored and administered correctly. However pharmacy provision was not in line with recommended levels. Pharmacy provision across critical care did not comply with recommendations from the Faculty of Intensive Care Medicine Core Standards.

In maternity, medicines were mostly stored securely throughout the service. However, we found issues in one instance of an unlocked

door to a medications storage area and instances of fridge temperatures not within required levels. We also found an instance that the room temperature where medication was being stored was not being recorded.

In children's services, the management of medicines was on the risk register with frequent comments about changes in practice identified, but we could not be assured that lessons were learned and changes in practice had taken place. We saw ten incidents reported where medication error had occurred but no lessons learned or shared outside of this directorate completed on the evidence provided from the trust.

There were arrangements in place to keep people safe and manage medicines for patients in end of life services.

In outpatients at Ealing, medicines were stored securely but the key holder for medicines cupboards was not always a clinically qualified staff member. At Northwick Park we found unused controlled drugs were not correctly disposed of in the haematology clinic.

There were good arrangements in place to manage medicines for patients who were being cared for in their own home or at MHH. Patients and carers were supported in ensuring they knew how to take or give the medication safely. Syringe drivers were available for appropriate patients.

However, provision of pharmacy staff trust wide did not meet recommended levels and no pharmacist was in place for patients cared for in the overnight intensive recovery unit (OIR).

Records

Patient records were a mixture of electronic and paper record. In areas such as medical wards, the completion of paper records was done with a variable degree of completeness. Some examples included non-recording of patient's weight, fluid balance charts not totalled, MRSA swab results not recorded or no score for waterlow skin assessment.

On surgical and critical care wards records completion by doctors, nursing staff and allied health professionals was mostly completed to a good standard. Information was legible and enabled staff to understand and deliver the required treatment and care to their patients.

On maternity wards the majority of the records were clear, logical and concise. Entries had been dated and signed.

However on children's wards, all COSHH assessments we looked at were out of date.

Summary of findings

In end of life care people's individual records were written and managed in a way that kept them safe. Records reviewed were accurate, legible, and up to date and stored securely.

In outpatients and diagnostic imaging we were told that records were available in time for clinics with only 1% of notes missing when needed. A temporary medical record was created when the main patient notes file could not be found. The method for tracking medical records was not always reliable.

Safeguarding

A trust safeguarding policy was in place and accessible to all staff on any trust computer. Ward nursing and medical staff knew how to access this policy and could identify who to contact if a safeguarding referral was needed.

The safeguarding children's policy was under review at the time of our inspection and the existing out of date policy was seen as a printed hardcopy.

Staff safeguarding level 1 and 2 training for adults was part of mandatory training and was routinely provided to all clinical staff. Similarly safeguarding children level 1 training was provided to nearly all staff including administrative and clerical staff. Safeguarding children level 2 was mandatory for all nurses and allied health professionals. Levels of training were variable with some departments achieving or above target and others below.

In our discussion with clinical staff, most were able to demonstrate their awareness of safeguarding and understood their responsibilities to adhere to safeguarding policies and procedures, including acting on possible concerns. Safeguarding was the subject of multi-disciplinary meetings across the trust.

Safeguarding investigations were carried out by matrons with broad root cause analysis experience but without specific safeguarding investigation training. They said they needed this training.

Mandatory Training

The trust target for attending mandatory training was 95% but we did find some variations in target. Staff within some departments were able to undertake mandatory training within work hours and others were only able to undertake this in their own time. Mandatory training rates were variable with some departments achieving targets and others not able to do so.

Many of the mandatory training modules were accessed thought the trust's online training system called ELMS. Staff reported positively about this system as they could track their own training and

received reminders when it was due for renewal. However some staff were concerned that they had to complete training in small modules on the new ELMS system rather than all in one or two days as they used to. They said this had a negative impact both on the training rates and the ability for staff to take time out to train.

Assessing and responding to patient risk

Staff knew how to escalate patients' needs in response to key risks that could affect their safety, such as staffing and bed capacity issues. There was an escalation and bed management policy in place with daily involvement of matrons and senior staff to address these risks.

The trust used a national early warning score (NEWS) system to identify when patients deteriorated using different observations such as heart rate, blood pressure and oxygen levels. The paediatric early warning tool (PEWS) and neonatal early warning tool was used in children's services.

Staff followed a patient observation and escalation policy, which was noted to reflect the guidelines from the National Institute of Clinical Excellence (NICE) CG 50, the National Patient Safety Agency (NPSA) (2007), the Department of Health; Competencies for Recognising and Responding to Acutely ill Patients in Hospital (2009) and the Royal College of Physicians; Standardising the Assessment of Acute Illness Severity in the NHS (2012).

We were concerned that there was no documentation in maternity to confirm that a 'fresh eye' check was undertaken routinely, throughout labour. A matron on the delivery suite at Northwick Park Hospital confirmed our findings. Fresh eyes practice means that another midwife, usually the labour ward lead, reviews the cardiotocograph (CTG) traces hourly. CTGs monitor fetal heart rate.

We found a mixed response in how well the nurses on the wards recognised a patient was approaching the last 12 months or less of life.

Nursing Staffing

In some areas there appeared to be no specific nursing staffing tool used to determine the level of nursing staffing needs. In other areas such as medical wards a patient acuity tool was used and the Shelford tool was used twice a year to review nursing establishments. Matrons also used their professional judgment to try to ensure safe staffing levels. As a result nurse to patient ratios varied on wards. The newly appointed director of nursing was attempting to understand and rationalise nurse staffing levels at the time of our inspection.

Summary of findings

Units within critical care used an acuity tool to assess the required staffing levels. Records we reviewed demonstrated all areas of critical care were consistently staffed at the required levels to meet the recommended nurse to patient ratios laid down by the Faculty of Intensive Care Medicine Core Standards.

Midwifery staffing levels was recognised as a challenge by the trust. There were sufficient specialist palliative care nurses for the number of acute beds at the trust.

Medical Staffing

Medical staffing levels throughout the trust were generally sufficient to provide safe care. However there was a lack of permanent consultants and over reliance on locums at Ealing medical wards and low senior overnight general medical cover at Northwick Park.

Medical staffing on eHDU in critical care at Northwick Park was not sufficient and care was provided by anaesthetists without critical care accreditation.

The maternity service was non-compliant with "The Royal College of Obstetricians: Safer Childbirth; Minimum Standards for organisation and delivery of care in labour, 2007" standards which state that, any unit with more than 5000 deliveries per year requires 168 hours of consultant presence per week.

Consultant cover in End of Life Care did not appear to be sufficient according to commissioning guidance.

Major incident awareness and training

The trust had a documented major incident and business continuity plan, which listed key risks that could affect the provision of care and treatment. The major incident plan provided clinical guidance and support to staff on treating patients of all age groups and included information on the triaging and management of patients suffering a range of injuries, including those caused by burns or blasts and chemical contamination.

Guidance for staff in the event of a major incident was available within the trust's major incident plan, which was also located in the department.

Community Health Services

Services for Adults

The trust had set a target of 80% for health and safety, basic life support, fire safety and equality, diversity and human rights training, and 90% for other mandatory and statutory trainings completion. This target was not met by the adults' community teams.

Summary of findings

Not all staff were routinely informed of trends and patterns of incidents in order to share learning, prevent reoccurrence and encourage practice improvement.

Although the average vacancy rate for adults community services was better than the hospital average the rate recorded for Harrow's district nursing teams was significantly higher, which translated into significant use of temporary staff. The trust was planning to suspend use of agency staff but had failed to assess local risks related to it.

In general, we found that medicines were correctly stored and administered.

Services for children young people and families

The safety of children and young people's services required improvement. This was because there were significant staff vacancies within the service. The trust had developed the health visitor clinical and academic hub, which had significantly helped to raise the profile of health visiting within the trust through publication of papers and nominations for national awards. With the work of the hub and streamlined recruitment processes there had been some success in recruitment but too many vacancies remained. The impact of vacancies was that many staff were trying to manage caseloads well above best practice guidance of 300 families per health visitor. Health visitors working in Brent and Ealing did not know how they would meet the requirement for all parents to have a visit at 28 weeks of pregnancy. This is a national target to be implemented from October 2015.

Therapy staff were also experiencing high demand and in some cases it resulted in long waits for treatment. Occupational therapists reported 12 months wait from assessment to treatment. Audiology services reported their current workload to meet the key performance indicator of children being seen in six weeks was not sustainable.

Staff worked hard to minimise the impact on patients but there were increased risks due to high caseloads.

Child protection supervision figures provided by the trust for July, August and September 2015 showed safeguarding supervision in health visiting team was generally above the trust's target of 90%. All staff we spoke with told us they had received training and were aware of processes to follow.

Summary of findings

A new electronic recording system had been introduced in September 2015. Staff told us they were confident the system would meet their information needs and it allowed flexibility with specific templates. It did not interface with the hospital system, which was seen as a problem.

Community health inpatient services

The trust reported low numbers of incidents. Those incidents that did occur were usually properly investigated and the outcomes feedback to staff.

The community hospitals were effective at making sure only suitable low risk patients were admitted. The hospitals had a clear process for identifying and responding to deteriorating patients. Patients who had deteriorated had been identified and transferred to the acute environment if necessary.

The community hospitals vacancy rates for registered nurses were too high. This meant that too many agency nurses with less knowledge of the patients and the unit were being used. There were not enough staff at the Denham unit to keep patients safe all the time.

Community end of life services

Safety across community health services for end of life care was good. Openness and transparency about safety was encouraged. Staff fully understood their responsibility to raise their concerns and report incidents and near misses. However we found some staff concerns such as missed appointments had not been reported as they should have been.

Incidents were investigated adequately; a root cause analysis was completed and learning points and actions identified. However some staff reported they did not always know the outcome or improvements made as a result of the incident and did not routinely know of issues raised by other areas or departments in the trust. Therefore it was difficult to identify risks and trends and improve consistency in practice across the whole of the trust's community services.

There were good arrangements in place to manage medicines for patients who were being cared for in their own home or at MHH. Patients and carers were supported in ensuring they knew how to take or give the medication safely. Syringe drivers were available for appropriate patients.

The CPCT was highly skilled in supporting patients who had complex health issues and requiring specialist palliative or EOL support. However there was some concern whether the generalist

Summary of findings

community (district) nurses always recognised a change or deterioration in a patient, which could indicate they were approaching the last 12 or less months of life, and then responded appropriately to it.

Safeguarding vulnerable adults and children and young people was given sufficient priority. Staff were aware of their role and responsibility in raising concerns and had received a level of training appropriate to their role. Training completion rate was better than the required CCG compliance of 90%.

Community dental services

We rated safe as requires improvement because: There was no clear system in place for identifying and learning from patient safety incidents. Mandatory training was not up to date (including basic life support) and staffing levels were insufficient. As a result, dental nurses often had to work at different sites to cover absences. There was an insufficient mix of skills across the service, as dental nurses had to cover administrative duties when the administrators were not working, as well as decontamination of dental instruments.

The service did not consistently identify or address safety concerns. For example, an incident occurred where a child trapped their fingers in a door. Staff had identified the door as a risk prior to the incident, but the trust had not addressed this.

There was a patient confidentiality risk at Acton Health where staff did not lock patient records away and the reception area was left unstaffed and accessible to the public.

However, we observed good practice and procedures in place for cleanliness, hygiene and infection control.

Are services at this trust effective?

Requires improvement

Evidence based care and treatment

The trust participated in some national and local audits. However, in some cases there were no clear action plans to indicate the improvements needed as a result of the audits were acted upon.

The trust provided treatment in line following national guidelines including National Institute of Health and Care Excellence (NICE) and other specialty guidelines according to the department, for example, College of Emergency Medicine (CEM) guidelines for patients care in the emergency department. Guidance was regularly discussed at governance meetings, disseminated to staff during team days. A range of clinical care pathways had been developed in

accordance with recognised guidance. However, medical inpatient services were not always effective particularly at Northwick Park. Nutrition and hydration was poorly managed with poor assessments, choice of food and support for those that needed it.

We found the surgical services were managed in accordance with the principles outlined in National Confidential Enquiry into Patient Outcome and Death (NCEPOD) classifications around access to emergency theatres and the Royal College of Surgeons (RCS) standards for unscheduled surgical care.

Multi-disciplinary team working across disciplines was effective at Northwick Park Hospital, and consent to care and treatment was obtained in line with relevant legislation and guidance. There were also policies and procedures in place which were based on up-to-date evidence-based guidance. However, staff at Ealing Hospital were not following the latest guidelines in relation to medical management of miscarriage.

The trust's response to the independent review of the use of the Liverpool Care Pathway (LCP) for the dying patient and the subsequent announcement of the phasing out of the LCP was to create a document call 'Last Days of Life Care Agreement' (LDLCA). This had been applied in some areas but was yet to be rolled out and adopted across the whole trust. Generalist ward staff did not always have the skills to recognise dying patients or to have difficult conversations with patients or families.

Pain relief

Pain relief was generally managed well in the trust with appropriate support from the trust wide pain team. However the emergency department at Northwick Park performed poorly in the national College of Emergency Medicine (CEM) audit (2013/14) in providing pain relief for patients with renal colic and fractured neck of femur.

The assessment of pain for critical care patients was in the process of being reviewed by the critical care 'Nursing Practice Group' at the time of our inspection. Members of the group told us they were reviewing working methods to ensure compliance with best practice guidance.

Nutrition and hydration

The provision of nutrition varied across the trust. It was poor at Northwick Park in particular. Patients were able to choose three meals each day from a menu which was provided by catering staff and jugs of water were left at the patient's bedside. Additional

snacks and hot drinks were also provided. However in some areas patients complained that meals were poorly presented in packs rather than on plates. Hot meals were served at the same time as cold puddings.

There was varied feedback on the food with some stating it tasted microwaved or was 'tasteless'. There was also a lack of choice at lunchtime and the menu did not change much for long stay patients.

We observed risks assessments in place for patient's nutritional needs and these had been reviewed as part of their progress reports.

A trust wide protocol was in place for fasting patients prior to surgical procedures. In addition to this, we saw there were fasting instructions within the letter sent to patients regarding their admission.

Where patients required intravenous fluids, these had been prescribed by the doctor. We saw that fluid balance charts were provided and used to monitor the patient input and output. However, these had not always been completed with respect to daily totals.

In some areas we saw that some MUST (Malnutrition Universal Screening Tool) charts were either incomplete or incorrectly recorded. The MUST template in use did not meet national guidance as some key sections were not included such as a body mass index calculation.

Patient outcomes

For emergency and urgent care the majority of the College of Emergency Medicine (CEM) audit results were worse than the national average, such as consultant sign-off. The standard states that three types of patients groups should be reviewed by a consultant prior to discharge. These were adults with non-traumatic chest pain, febrile children less than one year old and patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. The department performed worse than the UK average in all the eight measures as they achieved an average of 2% against the UK average of 14%.

There was a lack of national auditing on patient outcomes in medical care. The care of the elderly wards did not participate in fragility audits and claimed that a lack of permanent consultants prevented them from doing so. Staff were unaware of any national or local audits specific to infectious diseases or haematology.

At Ealing where some audits had taken place, the hospital had a worse than average performance in the national diabetes audit

Summary of findings

(NADIA) in 14 of 21 indicators including medicine errors, prescription errors, management errors, insulin errors, foot risk assessment in 24hrs, foot risk assessment during stay, meals, self- management of diabetes care, staff awareness of diabetes care, and staff knowledge on diabetes. Staff told us there had been specific teaching in relation to this audit such as safe prescribing of insulin. A new NADIA audit had recently been completed and staff believed they had improved their outcomes this year although the report had not yet been published. Other diabetes related audits that had been undertaken including acute kidney injury and foot examination although staff were not aware of the results of these either. Average length of stay (ALOS) was lower than the national average for elective patients but higher for non-elective, particularly in care of the elderly wards. We found discharges were often delayed which was contributing to this.

Patient surgical outcomes had been monitored and reviewed through formal national and local audit. Most outcomes were within or above the average comparator. However, there were areas which performed less well including the National Bowel Cancer Audit for 2014, the patient hip fracture audit for 2014, and the National Emergency Laparotomy Audit for 2014 and 2015.

Effectiveness of care provided across critical care was good at Ealing but not effective at Northwick Park and required improvement. Within eHDU at Northwick Park consultants caring for patients were not critical care accredited and less than the recommended proportion of nurses had an additional critical care qualification on this unit and Dryden HDU. There was inconsistent involvement of the multidisciplinary team across critical care and variable liaison with other areas of critical care in the trust. Patient outcomes for mortality and readmissions within 48 hours fell below the standard set nationally and locally. Evidence-based care bundles were in place but compliance with these demonstrated variable performance.

In maternity, one to one care during labour was good; around 98% had been reported in August and September 2015.The proportion of delivery methods were mostly in line with national expectations. Normal births were promoted; the rate of normal unassisted births averaged at over 60% from January to December 2014. However, the rate of non-elective caesareans was high, and averaged 19% between January to December 2014 which accounted for a high number of births. We were not aware of any actions to improve on this.

Summary of findings

Outcomes for children who used services were in line with expected ranges, with the exception of epilepsy care, which required improvements e.g. patient and parent information following first fit and the accident and emergency setting.

We did not see evidence of outpatient department audit or service monitoring for improvements. We did not see information about participation by the trust in accreditation schemes including the Imaging Services Accreditation Scheme (ISAS) or the Improving Quality in Physiological Services (IQIPS) accreditation scheme for audiology.

We saw evidence that the trust had variable performance in the National Cancer Patient Experience Survey 2014 some of which placed the trust in the bottom 20% of trusts.

Competent staff

The emergency department at Ealing was not compliant with nursing and clinical staffing guidance published by The Intercollegiate Standards for Children and Young People in Emergency Care Settings. This required nurses working in the children's ED to have a minimum level of knowledge, skills and competence in both emergency nursing skills for the care of children and young people.

Appraisal rates across the trust varied from above 80% to below 50% in some wards with a trust target of 95%. We received varied feedback regarding appraisals with some staff happy with their appraisal which they received regularly whereas others said they either rarely had them or not at all.

We saw that completion of mandatory training was acknowledged on the trust risk register. The steps for mitigating the risk included the introduction of an electronic learning system and weekly and monthly monitoring of compliance at divisional level.

Nurses who spoke with us in a focus group reported there was good support for professional development, with trust provision through the education learning and development department.

Throughout the trust, revalidation for nursing staff and for medical staff was supported by senior staff in line with Nursing and Midwifery Council and GMC requirements.

Multi-disciplinary working

We observed good multidisciplinary working on some wards and in some departments at all locations. In these instances, clinical staff knew all their patients and worked in a flexible way with other

members of the team. Multidisciplinary team (MDT) sessions were used to improve the discharge process and bed availability. However, multidisciplinary working was variable with a lack of cross site working in particular.

For example, we noted there were ITU beds available in Ealing Hospital's critical care unit when there was a shortage at Northwick Park. We raised this with staff, and they told us there had been no direct communication between Northwick Park ITU and the critical care unit at Ealing and therefore the bed availability was unknown.

We also noted that, in practice, the three hospital outpatient departments remained separate and each of these had different systems and processes for providing outpatient services from the speciality led clinics.

Seven day services

All in-patient and emergency departments provided seven day 24 hours per day services with out of hours consultant cover.

There was provision of emergency theatres at all times, including out of hours. Surgical patients were seen daily by a member of the surgical team for the speciality or by the on-call person.

Therapy services were mainly available Monday to Friday but with out of hours and weekend on-call cover.

Pharmacy was open Monday to Friday, 9am to 6pm with partial opening at weekends between 9am and 1pm.

The Specialist Palliative Care Teams provided face-to-face support from 8am to 5pm Monday to Friday. The trust's action plan to address the deficiencies in the 2014 NCDAH was to increase face-to-face contact from six to seven days per week. However since our last inspection of the hospital the service had been reduced from six days to five days per week due to a shortage of specialist nurses.

Two local hospices provided a 24-hour helpline for clinicians. They triaged the calls and directed the caller to the most appropriate support, such as the on-call SPCN or consultant.

We were told that diagnostic services staff had begun to function as an integrated team and worked across the three trust hospital sites. They had changed their working patterns to cover on-call working for evenings and weekends.

Access to information

The trust's computer system allowed staff to check records from any available terminal connected to the trust network. This meant, during discussions over the telephone with GP's and specialist

doctors, the clinicians could view the latest test results, past medical history and current observations. The system also made it easier for senior staff to check results, scan reports, identify and call back patients who had been discharged with a clinical problem unresolved.

Information and guidance for staff was available through the trust intranet site. Information available included policies and procedures related to each department. We saw notice boards on wards and in public areas had information displayed for staff and the patients. We saw examples of patients being given leaflets that explained their treatment.

In all areas, an electronic discharge summary was completed for each patient. Patient discharge information was communicated to GPs, with details of the treatment the patient had received. Care summaries were provided on discharge to ensure continuity of care within the community.

Staff had access to all main computers, including test results, diagnostics and patient record systems. There were sufficient computer points across the service to support staff. However, we noted some areas where this was not so. For example, staff in the accident and emergency for children did not have access to the information technology patient flow system called Symphony which is available at Ealing. This meant the system was not completely integrated in all areas.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff knowledge of consent was variable throughout the trust. Some staff accurately described consent principles, including best interest decisions for patients who did not have the capacity to consent to treatment and procedures.

Staff demonstrated good levels of knowledge regarding the Mental Capacity Act. However understanding of Deprivation of Liberty Safeguards was extremely variable, including amongst senior staff.

Mental Capacity Act (MCA) training was an “essential” subject for staff to attend as mandatory training and the content included consent and Deprivation of Liberty Safeguards (DoLS). However, some staff were not sure if they had undertaken this training. Gynaecology staff at Ealing Hospital, for example, told us that they had not had training on consent, the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DOLs).

We observed the correct consent forms were used where required despite the variability in staff knowledge.

Summary of findings

We observed staff asking patients for verbal consent prior to interventions such as positional changes and taking blood. Staff took care to explain why the intervention was required and we observed staff explaining the risks of not completing the task.

Staff we interviewed on children's wards were aware of the guidance with obtaining consent for children. They were able to demonstrate a good understanding of the Gillick competency and children were supported to make decisions where appropriate.

When reviewing end of life care, we looked at ten do not attempt cardio pulmonary resuscitation (DNACPR) forms. We found six to be completed correctly. The level of completion for the remaining four was variable.

An audit of compliance with expected standards around consent for in-patient wards was undertaken in July 2015. Results were variable and we did not see results for all areas. However, for example, a sample of consent forms reviewed included 37 relating to patients on surgical wards at Ealing Hospital. Of these 70.3% had been signed by the surgeon performing the operation but 24.3% had not been signed. The trust later informed us that they had been signed by another doctor trained/qualified to take consent and carry out the named procedure. One further form was illegible and operation notes were not available in the remaining one. Job title was stated in all consent forms reviewed. The benefits of having the surgery had been included in 97.2% and risks had been recorded in all forms reviewed. Responses from patients about consent presented favourable feedback in most of the questions asked. The lowest responses related to 25% of patients not having information about the type of anaesthetic they were to receive. An action plan had been developed from the findings and this included for example the provision of formal consent training. We did not see evidence of consent audit in outpatients and diagnostic imaging.

Community Health Services

Community services for Adults

Staff were clear about their responsibilities in line with the Mental Capacity Act 2005.

Patients had access to appropriate pain relief and community nurses monitored whether patients were adequately fed and hydrated.

The trust participated in the national audits of intermediate care to inform care delivery.

Summary of findings

We observed good multidisciplinary working and that staff shared information with others involved in patients care effectively to achieve best treatment outcomes.

We also noted many staff were not appraised and that teams in each of the three boroughs were working in isolation. It did not allow full integration and knowledge sharing. There was poor integration of services within the sexual health speciality.

Community services for children young people and families

There were processes in place to ensure that care and treatment delivered by staff followed best practice, such as NICE and other guidelines.

A wide range of audits had been undertaken and the outcome of audits were used to improve the care delivered. Various patient outcome measures were used by different teams and there were examples of accredited and evidenced based services being provided.

Staff reported good access and support for training and stated they had regular supervision and appraisals.

The health visitor clinical academic hub had developed a standardised induction pack for health visitors. There was a competency framework for staff at all levels and the induction pack included the competency framework; this was followed up as part of the appraisal process.

Staff generally reported good inter-professional and multi-agency working.

Although the electronic information system had only been operational since September 2015 health visitors were looking forward to the introduction of mobile working which they said would help to improve effectiveness.

Community inpatient services

Clinical staff in the community hospitals were following NICE and other clinical guidance to ensure patients achieved the best possible outcomes.

Multi-disciplinary teams worked well tot ether to provide patients with good outcomes. In particular physio and occupational therapists were well integrated and showed leadership in ensuring patients achieved their recovery goals.

Staff understood their responsibilities regarding consent for patients who may lack mental capacity and the actions that could be taken to prevent unnecessary restraint.

Summary of findings

Community end of life services

Patients were at risk of not receiving effective end of life care within the community. The CPCTs were made up of a highly skilled and knowledgeable staff group who supported patients with palliative care and end of life patients with complex health needs. However there were concerns the community district nursing teams across all boroughs had a "task based" approach to care and did not have the expertise or experience to recognise when a patient was in the last 12 months or less of their life and was deteriorating. This meant patients' who maybe dying because they were frail and elderly may not have the opportunity to discuss their wishes, put in place any advanced directive and receive care which was appropriate to their circumstances.

The implementation of a new electronic recording system was found to have caused some gaps in information sharing. It was seen as a positive move to have access to a 'live' document with a multidisciplinary team approach to provide joined up care for patients; however there were glitches in its use due to poor accessibility in the community and in some case lack of training. This made the system cumbersome and uncoordinated at times as staff were still accessing two systems.

Patients' care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. Patients' needs were assessed, their preferences were identified and care was planned in a holistic way taking into account their healthcare, psychological and social needs and included open communication with the patient and those close to them.

Care and treatment was monitored to ensure consistency of practice. After death or significant event reviews allowed staff to discuss what went well and address any areas for improvement. The CPCT participated in local and national audits and took action as a result of any findings in order to improve practices and care.

Community dental services

We rated effective as requires improvement because:

The patient pathway was not always timely. There was a long waiting list for specialist services (endodontics and periodontics). There were delays and poor coordination when people were referred for further treatment outside of the service. Patients who required treatment under general anaesthetic had to be referred to external hospitals because there was no suitable service available

within the trust. This often involved long waiting times and delays to treatment which could be detrimental to the patient's oral health. For example some patients missed the optimum time for premolar tooth extraction.

Systems to manage patient records were cumbersome and uncoordinated. Some records were recorded using an electronic system whilst some were hand written. This was partly due to limited availability of software and equipment and partly due to staff preference and insufficient training. At one location all appointments and records were paper based.

There was no set protocol for recording consent within the service and dentists differed in which treatments they sought written consent for. However, we did not feel that this posed a risk to patient safety. We observed dentists obtaining appropriate implied and/or verbal consent.

However, staff had the knowledge, skills and competence to carry out their roles and responsibilities effectively and some were undertaking courses to further their learning and development.

Are services at this trust caring?

Good

Staff at the trust generally provided compassionate care and ensured that patients were treated with dignity and respect. Patients, on the whole, spoke positively about the care and treatment they had received and we observed many positive interactions. Staff provided patients and their families with emotional support and comforted patients who were anxious and kept them informed about their treatment.

Feedback from patients, relatives and carers was generally positive. Most patients and relatives we spoke with during our visits spoke highly of their care and the staff providing it. The response rate to the Friends and Family Test in the trust was generally, and the majority of respondents provided positive feedback. There were positive comments from patients about the care received, and the attitude of motivated and considerate staff. They told us they were involved in the decision-making process and had been given clear information about treatment options.

Compassionate Care

The emergency department (ED) provided compassionate care and ensured that patients were treated with dignity and respect.

Inpatient medical services were caring but there were some areas that should improve. Patient feedback was that they were cared for

with privacy and dignity. Patients, family and friends reported being involved in their care and emotional support was available. However, we observed some instances where patients were not involved in their care because staff talked over them.

Patients on surgical wards reported positively with regard to the quality and standards of care they received from doctors and nurses. Staff respected the individuality and needs of patients and treated them with kindness, courteously and with respect. Patients told us their privacy and dignity was respected and they were involved in decisions about their treatment and care.

Patients provided positive feedback about all levels of staff on the critical care unit. They told us staff were friendly and made them feel as if "nothing is too much trouble".

Across the maternity service we found that staff ensured patient's dignity and respect. We observed that patients could close their curtains around their beds in bays for privacy and that staff knocked on doors before entering patient rooms.

We saw good interactions between staff, children and families. All parents we spoke with during the inspection told us that they had been treated with respect and dignity by the staff.

The results from the NCDAH local survey of bereaved relatives were in line with the National Survey of Bereaved People (VOICES) 2014; 66% of people thought the doctors and 70% of people thought the nurses always treated their relative with respect and dignity during the last two days of life.

Mostly we saw outpatient and diagnostic services staff interacting with patients in a caring, compassionate way. For example we saw staff in outpatients informing patients of waiting times for clinics. However, at Northwick Park OPD, we found at times staff were not always caring or respectful of patients. We witnessed three separate incidents of staff being rude to patients.

Understanding and involvement of patients and those close to them

Most patients told us staff took time to explain treatment, test results, treatment options, their implications and side effects of medication in a way they could understand. Patients and their relatives could speak with staff in private if necessary. Patients said nurses and doctors were understanding and supportive. Patients told us they were involved in decisions about their care and the team checked they were happy with how their treatment was progressing.

Summary of findings

Some relatives of patients in medical care wards told us they did not receive enough information and one patient was of the opinion that their condition had not been diagnosed correctly.

Staff recognised when patients needed additional support through the use of expertise and skills of specialist nurses and allied health professionals. They were able to access language interpreters and had other resources available to assist in effective communication.

In maternity, the antenatal records we checked did not have birth plans in place. However across the service patients told us that they were well informed and were involved in decisions about their care or treatment.

We observed staff explaining to children procedures and what children were going to have done to them in a way that the child understood. They spoke to children in a calming and supporting manner.

Patients who were identified as approaching the end of their life were given the opportunity to create an advanced cared plan. This gave patients the time to discuss their preferred priorities for care and make decisions about where they would like to be cared for and how.

Results of the national cancer patient survey 2014 showed the trust performed less well than the national average for 'clear written information about what patients should / should not do post discharge'. The trust scored 82% against a national average of 85%.

In the same survey the trust scored better than the national average for 'Family definitely given all information needed to help care at home' at 65% against a national average of 60%.

Emotional support

We saw staff providing emotional support to patients as part of their day to day work. Patients described staff as "reassuring" and "sympathetic" when completing procedures such as putting in IV lines. We observed staff approaching patients in a sensitive manner and providing a calming influence when patients were anxious.

The trust counselling services could be accessed as requested during the working week Monday to Friday.

The trust wide spiritual care and chaplaincy team were available for pastoral support for children and their families; for adult patients and bereaved relatives as well as staff. This was available 24 hours a day via an on-call system. There was a specialist bereavement midwife in post to support parents in cases of stillbirth or neonatal death.

Summary of findings

Staff understood the impact that a person's care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially. Regular checks of patient wellbeing were taken in the form of comfort rounds. Family and carers were encouraged to visit and be involved where possible in supporting their relative. Carers who spoke with us reported they had been involved in discussions.

Community Health Services

Community services for adults

Patients' feedback was positive. They told us that staff listened to them and understood their needs.

Nursing and therapy staff showed respect for patients and their families and a commitment to promoting the dignity of patients.

Staff communicated well with patients and provided them with information on how to manage their condition and options of treatments available.

Community services for children young people and families

Staff we spoke with were very passionate about their roles and were very dedicated to making sure the people they cared for were provided with the best care possible.

Parents we spoke with told us that they were treated with compassion, dignity and respect. They were involved in discussions about treatment and care options and were able to make decisions.

During our inspection we observed children and their family and carers being treated with kindness and compassion.

Parents told us they were able to express their opinions and were included in making decisions about future care and treatment plans.

Community inpatient services

All the patients and families we spoke with were very positive about the care they had received in the community hospitals. One person told us, "They have been great. I have got all the care I needed". Another said, "The nurses are nice and they have been trying to get me well enough to go home".

Patients are fully involved in their care planning. The MDT team agree individual recovery goals for each person so that they are able to achieve as independent living as possible.

Summary of findings

We observed that staff were caring and provide patients with emotional support. This also included professional psychological support for a number of patients.

Community end of life services

Community health services provided good care for patients at the end of their life. We spoke with two patients and one relative in their own home; one inpatient and their relative at Meadow House Hospice; three day hospice patients and reviewed thank you cards. Patients we spoke with told us “nothing was too much trouble” for the staff.

We observed staff treating patients and those close to them with compassion and ensuring their dignity was maintained. Staff always asked permission before entering people’s homes or the rooms they were being cared for in. Patients told us “everyone is very friendly”.

Patients and their families were involved and encouraged to be partners in their care and in making decisions. Patients told us the staff were very helpful as they explained their condition to them and those important to them and addressed any concerns they had. Patients visiting the day hospice told us they each had some time with a nurse and/or doctor to discuss any problems or concerns. They told us they discussed symptom control and medication options. One CNS we spoke with told us they were “proud that they could take time to get to know the patient and help them make plans with their families.” It was clear from staff interactions with patients that they gave each patient the emotional support they needed. Bereavement support was offered to people important to the deceased and staff checked on their welfare following the death of their relative or friend.

Community dental services

We rated caring as good because:

We found staff to be caring and passionate about their work. They were hard working, committed and were proud of the service they provided. People were treated with respect and kindness during interactions with staff. They were communicated with in a way that they could understand. Patients were supported in managing their own oral health and care when they could.

Patients, parents, partners and carers we spoke to said they were happy with the service. They said that they were well-informed and were involved in decisions. One patient's parent told us that they thought the service was excellent, and responsive to their needs.

Summary of findings

They had been able to rearrange an appointment when it was difficult to fit it around their work, and also said it was helpful that they had received a phone call to remind them of the appointment the day before.

Are services at this trust responsive?

Requires improvement

Responsiveness to the needs of patients required improvement in most parts of the trust.

Service planning and delivery to meet the needs of local people

There had been a continuous and persistent deterioration of the emergency department's performance against the four hour target to see and treat people. Patients did not always receive care and treatment in a timely way. The department had consistently failed to meet key national performance standards for emergency departments.

Black breaches increased (waiting more than an hour in an ambulance because they could not be admitted to an Emergency department due to lack of beds) had occurred in significant numbers over the previous 18 months. Between September 2014 and August 2015, there were 1,389 black breaches at the trust.

Medical services were not responsive to patient needs in relation to the patient pathway. The highest pressing issue the services had was flow with poor performance and delays at most points of the patient pathway such as admission, transfer from AAU/AMU and discharge.

In surgery, there were no formal admission pathways for some patient conditions. Criterion for admission to the surgical assessment unit was not always adhered to. Adjusted referral to treatment within 18 weeks was worse than the England average between the period of September 2014 and April 2015 for five surgical specialties.

Bed occupancy across critical care was consistently above the national average and the service was identified as having the largest shortfall of beds within the North West London Critical Care Network. Capacity issues had affected elective surgical activity but no plans were in place to mitigate the capacity issues at the time of our inspection. There was a high proportion of patents discharged out of hours and significantly more non-clinical transfers than in other similar units nationally and across the local network.

In maternity and gynaecology, there were delays in starting inductions and elective caesarean sections due to lack of staffing. Midwives were used to assist during caesarean sections at night due

to a lack of nurses. Patients told us that, on occasions, the antenatal clinic at Northwick Park Hospital would run up to 2 hours late due to lack of staff. Birth plans were not always completed. This meant women may not have the opportunity to express their wishes and have them acted upon.

The service for children was not always responsive to meeting the needs of children and young people with waiting times in Accident and Emergency and in outpatients' services with some identified additional delays in receiving timely appointments. The service was achieving 93% of patients being seen within 18 week of referral for treatment.

In end of life care, we found that the Last Days of Life Care Agreement (LCDCA) was individualised and holistic to reflect the patient's needs and wishes, and took into account the views of the people who were important to them. However this was a new document and not all health professionals had started to use it. We did not find it in use in any of the patient records we looked at. This meant there could be potential gaps in the discussions held by clinicians who may only take into account the patients clinical needs and not enter into other issues that could be important those involved in the patient's care.

Overall we judged that responsiveness of outpatient and diagnostic services was good reflecting the greater degree of integration of this service across the trust. Patients referred to the outpatients service were given the first available appointment at one of the trust's hospitals could choose to attend one of the other two hospitals run by the trust. The trust had a process for identifying the patients near to having waited 18 weeks and escalated this information to the speciality clinics to which patients' had been referred.

Access and Flow

Medical services were meeting the admitted referral to treatment 18 week 90% target in all specialities other than cardiology and general medicine. Medical patients flowed with little delay between A&E or admission, through the AMU to a specialist ward. There were no ward based discharge coordinators so continuing care assessments and other social services paperwork either had to be completed by the nurses on the ward or the hospital wide discharge coordinators. Senior staff acknowledged there was a discharge issue but said, in their opinion, the issue was mostly a lack of nursing home placements in the community.

Summary of findings

Information related to referral to treatment (RTT) within 18 weeks was supplied for the trust and was not location specific. This indicated five surgical specialities not meeting the targets, including; general surgery (69.1%) RTT, trauma and orthopaedics, (83.4%), urology, (83.2%), ENT (82.8%) and oral surgery, (74%).

Between January and June 2015, ICNARC data showed the number of early discharges from the critical care units was in line with other similar units. There were more delayed discharges from critical care than on other similar units according to ICNARC data. Staff explained delayed discharges occurred due to the availability of beds on the hospital wards.

Patients discharged from critical care 'out of hours' between 10pm and 7am are nationally associated with worse outcomes and ICNARC data from January to June 2015 demonstrated there were generally more out of hours discharges from critical care than in other similar units, although this improved on the last quarter of data collection to less than the national average. Data from the North West London Critical Care Network showed there were slightly more out of hours discharges than on other critical care units in the local area.

Staff and patients told us that there were frequent delays in starting elective caesarean sections, induction of labour and that there were delays in discharge. We were told this was due to staff shortage. We were told that, on some occasions, midwives working the night shift would have to scrub to assist in the theatre due to lack of nursing staff. Patients told us that, on occasions, the antenatal clinic at Northwick Park Hospital would run up to 2 hours late due to lack of staff.

Bed occupancy rates in maternity services from October 2014 to March 1015 were between approximately 60-63%. This was slightly higher than the England average of 59%.

Thirty-nine of the elective admissions (28%) among children in the under two year age group and 101 (72%) of the elective admissions in the above two year to 17 age group had a length of stay of one day. This meant that the trust's median length of stay for children for non-elective stays was higher than the national average.

The multiple admission rate for children was 48%, which was above the England average (17.4%).

Bed occupancy was 85% with admissions to children's ward between April and July 2015. Cases totalled was evidenced as 859 but there were two gaps in the data received.

Summary of findings

The trust had a backlog across the board of patients being referred for outpatient treatment. Hospital data showed 386 patients across all specialities were waiting more than 18 weeks for an appointment.

The highest proportion of above 18-week waits (June 2015) were in cardiology 46% general surgery 38.9%; oral surgery 23.9%; colorectal surgery 11.9%; gastroenterology 17.2% and urology 28.8%. Service managers for surgery and urology told us extra clinics had been offered to address the backlog, but these would cease in November 2015 due to financial pressures. The trust monitored the backlogs on a daily basis and we were told held a weekly meeting across all sites to discuss progress. However, the weekly meeting had been cancelled during the week we inspected.

Meeting people's individual needs

Staff had access to translation services by way of a telephone interpreter system. They told us that the system worked well whenever they were required to use it. We saw patient information and advice leaflets. However, most were in English and not in any other language or format.

Senior staff at Ealing described having a lack of resource to ensure care for people with dementia would meet the actions in the dementia plan for the trust as they only had one Clinical Nurse Specialist covering 300 beds across all care of the elderly sites plus dementia champions for each ward. They told us they received no budget from the CQUIN payments for meeting the dementia targets and together they said this meant they were not meeting some of the CQUIN targets. Although it was easier to meet the target at other sites due to electronic recording, it was paper based at EH and no administrative support was budgeted. However dementia care bundles were in place although some staff were not aware of them and we found the CQUIN assessment was not always conducted in AMU. Overall trust screening for dementia was 77.8% and assessment was 93.7% against a target of 90%.

Surgical services were accessible to all regardless of disabilities. Arrangements had been made to make facilities accessible with appropriate aids. Wards provided single sex accommodation and access to separate toilet and bathing facilities. Multidisciplinary meetings took place specifically for long stay patients, during which progress was discussed along with rehabilitation needs. Arrangements for on-going care took account of individual needs of people being discharged with complex health and social care needs.

Staff demonstrated their awareness of the needs of different cultures and religions by describing how differently certain groups

viewed the management of dying patients as well the possibility of organ donation. Staff told us they respected the beliefs of different cultures and religions but tried to do what was best for the patient and support the relatives accordingly.

In maternity and gynaecology there was a dedicated team caring for teenagers and young parents to meet their specific needs. There was specialist support for women with a previous caesarean section and there was a VBAC (Vaginal Birth after Caesarean) programme. Other specialist support available included diabetic, female genital mutilation, bereavement and infant feeding.

There was specialist support for caring for children with complex which includes diabetes, asthma and epilepsy. There were identified Clinical Nurse Specialists for learning disabilities.

Both the bereavement and mortuary services took into account people's religious customs and beliefs and were flexible around people's needs. The bereavement office supported families from other countries by sign posting them to the right authorities to arrange the repatriation of the body. In other cases, where there was little or no money for a funeral, they arranged a funeral through the local authority.

Some of the facilities were not suitable to meet the needs of patients, for example, the haematology day care service at Northwick Park. Some areas of outpatients at Ealing were cramped and we observed a partially sighted patient in a wheelchair waiting in the corridor for the orthopaedic clinic. Staff told us there was not room in the waiting room for the wheel chair.

Learning from complaints and concerns

The trust had a complaints and concerns policy. We saw a copy dated October 2014 and this policy had been updated to take account of the Francis enquiry recommendations.

We saw information displayed throughout the trust that explained to patients how they could make complaints and give feedback. This information was mainly in English. Nursing staff were aware of how to manage complaints and how to support patients who wished to complain. The trust provided a leaflet for patients 'Listening, responding and improving your experience' which detailed the Patient Advice and Liaison service (PALS) service. We spoke with both clinical and non-clinical staff who told us they knew how to put patients in touch with the Patient Advice and Liaison Service (PALS). Information about PALS was displayed in patient areas at the trust. Some patients we spoke to were not clear about how they would go about making a complaint. They had not been provided with information about this.

Summary of findings

We reviewed written communications to complainants, some of which indicated a detailed approach had been taken. Others were less detailed. Letters generally included an apology and provided a formal record of the investigative process and conclusion.

We saw in some cases complaints received were displayed on ward safety boards. The boards also included a 'you said, we did', which demonstrated how the staff listen to the feedback from the Friends and Family Test or complaints. However in some cases when we reviewed complaint handling for example in haematology outpatient services, the trust information showed five complaints had been closed, but no information was included about how they were resolved.

The trust merger has highlighted different standards for handling complaints despite having one procedure. There is a backlog of complaints at Northwick Park in particular, with Ealing seeming to have a better control/process. There is a need to provide training for those staff responding to complaints.

Community Health Services

Community services for adults

Staff were not routinely informed of trends and patterns to complaints, including these received by other teams, in order to share learning and encourage practice improvement.

Podiatrist services in Brent had high non-attendance rate, at the same time patients were required to wait for up to 22 days for a routine appointment. Among other teams there were also long waiting times to access some of the speech and language therapy community services or continence services. In addition, tissue viability services had limited capacity to respond promptly to referrals.

We noted staff were aware of patients' individual needs and of the diverse population they were providing services to. There was a suitable service provision at night, and during weekends. Services were able to respond to urgent referrals.

Community services for children young people and adults

We saw examples of services designed to meet the needs of particular groups of patients. For example the new integrated service for children up to five years in Ealing and the family nurse partnership a specially designed programme for women under the age of 20, having their first baby.

Summary of findings

On-line interpretation was used very regularly and we were told this service worked well. We observed cultural awareness demonstrated on visits we undertook with health visitors and in a speech and language therapy clinic we observed.

Services were able to be flexible to work with vulnerable people. For example offering longer sessions to patients where English was not their first language or arranging visits to environments most suitable for the child or their family.

To ensure patients had good access to the service health visitors offered clinic appointments but there were also opportunities for clients to telephone and "drop in" ensuring an immediate response if this was required. Speech and language therapy groups and clinic times were arranged around the needs of their patients.

The service overall received a low number of complaints and records indicated that complaints were dealt with appropriately as guided by the trust's policy and procedures.

Community inpatient services

The community hospitals were willing to take all the patients who were physically well enough to be admitted. They were willing to take patients who needed high levels of support including psychological support.

The community hospitals were not always ensuring that patients with memory needs were being identified and their care was not being adapted to meet their individual needs.

Complaints and other forms of feedback were taken seriously by the community hospital. Changes were made as a result of patient feedback.

Community end of life services

End of life care services were organised and delivered to meet people's individual needs. There was an emphasis on providing a flexible service which promoted patient choice and continuity of care. Care and treatment was provided in a timely manner and co-ordinated with other community services, such as primary care providers and Marie Curie, which ensured patients received the most suitable care, equipment and support for them and their social circumstances.

There were open channels of communication between the trust's community healthcare professionals and their social and healthcare colleagues within the boroughs they worked in. The CPCT supported

patients with palliative and end of life care; and provided advice and guidance to community nurses who were supporting patients at the end of their life, this ensured patients received care at the right time and in the most appropriate way for them

The needs of different people were taken into account when planning and delivering care. Community nurses were aware of patients' individual needs and of the diverse population they were providing services to. There was a suitable service provision at night and during weekends, and services were able to respond to urgent referrals.

There were few complaints regarding end of life and palliative care. The CPCT told us they tried to deal with any complaints at the time they were raised and they would support people in making an official complaint if they were not happy with the way it was addressed within the service. The CPCT told us they were aware of any complaints made, the outcome and any learning from it; however the community nurses were not routinely informed of trends and patterns in relation to complaints and therefore unaware of any shared learning or practice improvement as a result.

Community dental services

We rated responsive as requires improvement because:

Patients did not always have access to care and treatment needed in a timely manner due to waiting times for specialist services (endodontics and periodontics). The service did not have an effective general anaesthetic referral pathway because there was no appropriate general anaesthetic service within the trust. There were no leaflets available in any language other than English.

Are services at this trust well-led?

Requires improvement 

The trust had recently come out of a protracted period of delayed merger. This had had a negative effect on the quality of leadership at trust board and departmental level. A new chief executive had recently been appointed and the trust was in the process of recruiting an almost entirely new executive team. There had been a succession of interim post holders in recent times for most executive team and senior manager posts.

We saw little evidence of integration between the main acute sites within the trust and in addition the community services arm was not integrated with the rest of the trust. While most staff valued their local leadership, many felt that the leadership away from their location was remote and not visible.

The trust was also operating in the context of "Shaping a healthier future" designed to re-align services for patients in North West

London. During our inspection we came across a degree of uncertainty about how this would affect services and staff, particularly but not exclusively at Ealing. Staff there reported a lack of communication in this respect.

The trust had a draft clinical strategy dated September 2015. The document lacked detail including time frames for work to achieve the trust goals.

Vision and strategy

At the time of inspection the trust vision and strategy in the light of "Shaping a healthier future" had not been finalised or communicated to trust staff. The trust had a business plan for 2015-16 but this did not include a vision.

Individual departments had varying development of their own vision and strategy and varying staff understanding of trust wide and their own department's strategy.

The vision and strategy of the emergency department was not made clear to the local leadership by the corporate management of the trust. Most of the staff we spoke with were not able to articulate the vision and strategy of the trust. Senior staff said there was little strategic and leadership direction from the corporate team, even though they had their own ideas on the vision of the emergency department.

There was a lack of strategic direction for medical services and this was leading to uncertainty among staff, particularly at Ealing. We were told that the development of the surgical directorate strategic aims was in progress and would need time to be embedded into practice. The on-going vision for critical care was to sustain the current service and there were no additional strategies in place for development.

The Trust had a clear vision and strategy however the staff we spoke with did not demonstrate awareness or understanding of it. In children's services, staff confirmed that they were aware of the local strategy but not all staff could confirm awareness of the trust wide strategy.

The trust clinical strategy made limited reference to the challenges faced by outpatient services.

We found there was a mixed response to understanding the trust's vision and strategy in end of life services. Most staff we spoke with said the strategy and vision was to provide good quality safe care however they could not explain the strategy to achieve this. The trust had recently written an EOLC strategy which was currently in a draft format and out for consultation.

Summary of findings

Governance, risk management and quality measurement

We were shown a trust governance structure listing committees and reporting lines to the trust board. This structure had been introduced just prior to our inspection and clearly had not had time to become embedded in practice or in the understanding of managers and staff. We viewed the trust governance arrangements in the light of the fact that cross site working including all the locations of the trust either had not yet begun in a meaningful way or was embryonic.

We did not find uniform governance and risk management processes across the different sites of the trust or between different departments and had difficulty understanding how this multiplicity of arrangements could be managed in a coherent way by the trust. For example, information about risks, governance and monitoring for outpatient and diagnostic services were inconsistent and lacked coherence. Diagnostic services were collecting and monitoring information inconsistently across the three hospital sites. There was a lack of trust oversight of governance data for diagnostic and outpatient departments and information provided lacked reliability.

In children's services, there was evidence of incident reporting and audit, with identified themes or trends but saw no supportive data included for lessons learned. Governance arrangements were developed and performance monitored but there were identified areas that were not addressed. We found risk issues which were not dealt with in a timely way. We saw the risk register within the recovery area for children in theatre which was not children focused and had no improvement plan.

In maternity and gynaecology, we were told that governance meetings were meant to be held monthly across the maternity and gynaecology service. However, we were only provided with minutes of meetings held in May, June and September 2015.

Senior critical care staff described attempts at branching out their clinical governance activities to share learning with other areas, such as surgery, as being met with resistance from senior trust staff. They said, in their opinion, that this was a wasted learning opportunity which could improve safety across all areas of the trust.

Senior nurses who spoke with us in a focus group meeting reported, since the appointment of the new CEO, changes in risk management and governance structures had given them more assurances. For example, the structured reporting via dashboards and key performance indicators (KPIs) was more effective in terms of achieving cost savings. They said the direction of travel was better with respect to reporting safety, quality and the patient experience.

Summary of findings

A risk register was in place for medical wards that was up to date which included some of our concerns such as bed capacity, staffing, and temperature controls plus actions were recorded to overcome these risks. However, many areas of our concerns were not included such as nutrition, discharge, and the environment. In addition, no dates for completing actions were recorded and some risks had been on the register for over two years.

Leadership

Most staff we spoke to in all departments and locations were positive about their local and departmental leadership. Most spoke of feeling supported and respected.

Comments about trust wide and executive team leadership and some divisional leads were less favourable and staff said they were less visible.

At the time of the inspection, there was a lack of joint ownership of the issues faced by the emergency departments across the trust, because the local leadership and the overall trust leadership vision of the department were not aligned with each other.

Leadership accountabilities appeared to be unclear in medical care. For example, there was a deputy head of nursing and general manager for care of the elderly services with job descriptions that included having oversight of all the trust sites providing care of the elderly wards. However, we were told the deputy head of nursing was not able to have oversight of sites other than Ealing, whilst the rest of the sites were overseen by the Divisional Director of Nursing.

Most managers appeared to be based at Northwick Park. Matrons reported feeling supported and having regular communications, as well as being able to attend meetings. The latter was said to be difficult due to travel but there were video links to facilitate engagement.

Senior nurses who spoke with us in a focus group indicated that it was difficult to sustain a presence across three sites, as well as community. We were told it was difficult to manage staff expectation of their visibility across sites.

We found the lead roles and accountability of the present OPD leadership structure lacked clarity because lines of accountability for outpatients and diagnostic services were split between four divisions.

Fit and Proper Persons Requirement

Summary of findings

We reviewed twelve sets of executive or non-executive personnel files. 3 of the twelve files had evidence of FPPR checks and gaps were found in these. 3 files had evidence of DBS checks. One file had director and insolvency checks. On this basis the trust was not compliant with FPPR requirements.

Culture

Culture and morale within the trust was affected by uncertainty over the continuation of some services, particularly at Ealing but uncertainty was a feature at all locations.

Within that context, staff told us they perceived themselves respected and valued by their colleagues; were able to share ideas and suggestions and they were listened to. The overall culture was described as being friendly, like a family, with mutual help to one another between staff grades and specialities.

We were told by nursing staff the culture was open and enabled them to speak up and they had confidence things would be dealt with and that confidentiality was also respected. We did not see evidence nor were we made aware of any bullying or unfair or discriminatory treatment.

Public and staff engagement

Patient focus groups were used to allow the public to share their experiences and shape certain aspects of the critical care service. For example the critical care follow up clinic assumed its current format based upon feedback from previous patients and their relatives. Feedback from patients and their relatives was also obtained via feedback cards which could highlight suggestions for future improvement or praise anything the unit was doing particularly well. However staff in the emergency department told us there was little attempt to gain public feedback in ED.

There were weekly bulletins to staff from the chief executive. Staff did acknowledge there were walk-rounds and forums but did not feel they were regular.

Surgical staff indicated they were engaged and told us they could share their ideas and suggestions. The directorate managers told us staff had been invited to contribute to the development of the surgical strategy, and several workshops had been held. All the staff in the Specialist Palliative Care Team told us their opinion was valued and they said their thoughts and views were reflected in the planning of the service.

Staff told us the trust took part in the excellence awards, the trust's staff excellence awards which recognised individuals and teams who go above and beyond the high standards expected.

Summary of findings

Staff at Ealing Hospital told us that they did not feel engaged or valued by management. They told us they did not feel listened to or involved in the trust strategy.

Innovation, improvement and sustainability

At Northwick Park, the opening of the new emergency department represented a substantial improvement in the provision of urgent and emergency services at the hospital, so that emergency care and treatment was provided in a suitable environment. The newly built 64 medical bed (AMU) unit due to open shortly was due to ease the pressure of the emergency department. There were concerns that staffing this unit might lead to resource pressure elsewhere in the trust.

There were plans to improve the alcohol liaison service. This included a new day unit to allow detox of otherwise medically fit patients without effecting capacity on medical wards.

There was due to be a project called 'Breaking the cycle' which was to review and reconfigure services to improve the emergency pathway and bed management in the trust. However there was still a need to review processes within ED and bed management and not rely solely on this initiative.

A smartphone application designed to assist junior doctors with prescribing on critical care was in the process of being developed at the time of our inspection. Senior staff told us they believed providing information for staff in an accessible and up to date manner would assist engagement with best practice prescribing.

Jack's Place, for children, was recently refurbished based on an idea following staff and children and young people's feedback. The ward's castle like features and dungeon door to the matron's office appeals to all across this client group.

Community Health Services

Community services for adults

Staff did not feel fully engaged and that they could influence changes within the organisation. They were not fully aware of the trust's vision and the direction organisation was taking in order to develop community services.

The trust did not have cohesive workforce strategy. Each of the three borough teams, as well as some of the teams working within the same specialities, were working in isolation and the trust failed to utilise opportunities linked to working in a larger, integrated care organisation.

Summary of findings

We also noted local teams were well managed by experienced and knowledgeable team leaders and managers. Staff were very motivated aiming to deliver patient centred services.

Community services for children young people and families

We had a mixed picture regarding staff members' view of the trust and their place within the organisation. Most staff we spoke with said that, in their opinion, the acute service did not understand community services. They were of the opinion that the focus of the organisation tended to be on acute services and community services tended to get lost within the larger organisation.

We also received variable feedback about the level of staff engagement. For example there were cross borough forums for health visitor staff at all levels and we were informed some staff had said this was the first time their voice was heard. However, school nurses in Harrow said they had not had the opportunity until quite late in the tendering process to be involved in writing the bid for school nursing services.

Staff were highly committed to providing a good service to their patients. However due to staff shortages and large caseloads this placed a lot of pressure on staff resulting in them working extra hours. Our conclusion was services were being sustained due to the commitment of staff and the support of local managers.

We saw there were clear strategies for recruiting staff and developing services. Staff we spoke with were aware of these.

There was a comprehensive programme of audits in place and processes to feedback information to staff via newsletters, emails and staff meetings. Staff were informed about the outcome of complaints and incidents within their area of practice. Team managers would feedback to the team if an action plan was required following an incident.

Staff generally reported good supportive leadership at local level. We met some very committed and enthusiastic managers who were working hard to develop and improve their services.

We saw good examples of innovation by the health visitor clinical and academic hub and speech and language therapy schools buy in service.

Community inpatient services

Services, processes and standards were variable across the three community hospitals. There is no single clear process of management and clinical governance.

Summary of findings

There was a lack of clarity over medical leadership in the community hospitals. Doctors at Willesden and the Denham unit told us that they reported to the trust medical director but doctors at Clay ponds said they reported to the clinical director for the medical division.

The vast majority of the staff we spoke with were proud of the care they gave to patients and were proud to work in their own hospitals. They did not share the same pride in working for the trust.

Community end of life services

The leadership, governance and culture at a local level promoted good quality person-centred EOLC. The senior staff prioritised safe, high quality and compassionate care through clear lines of leadership and an open culture. All staff were committed to providing safe and good quality care. There was a culture of collective responsibility between the local teams and many opportunities to discuss patient needs and review cases.

Consultants within the CPCT had written the draft EOLC strategy which was currently out for consultation. The strategy was developed through regular engagement with internal and external stakeholders, which included people who used the service, staff, commissioners and other organisations.

While staff were engaged at a local level this was not echoed at trust level. They were not fully aware of the trust's vision or direction the organisation was taking in order to develop EOLC community services and did not feel they could influence changes within the organisation. The trust did not have a cohesive workforce strategy; each of the three borough teams, as well as some of the teams working within the same specialities, were working in isolation and the trust failed to utilise opportunities to create one integrated care organisation. Staff at MHH told us they were “slightly in a bubble and could be autonomous” and “the services across the community were working in spite of everything else.” Staff working on the Ealing side of the trust were particularly concerned and voiced their worry about the uncertainty of their future since the merger with Northwick Park and Central Middlesex Hospital’s and the creation of the new trust.

Patient views regarding the community nursing services were collected through the friends and family test. The results were very positive with an average of 97% of patients saying they would recommend the service to their friends or family. The CPCT engaged staff and patients in finding ways to improve services. Receiving information through survey cards proved difficult as they were rarely returned therefore they engaged patients and their families through informal one to one ‘chats’ about the service.

Summary of findings

Community dental services

We rated the service as requires improvement for well-led because:

Staff were not aware of the trust vision and strategy. We did not see evidence of a vision or strategy at a local level. The main aim seemed to be to maintain the current service within the financial constraints. Staff indicated that the service was stand-alone and remote, with little involvement with the trust. Trust-level management was not visible. Managers within the service were based at a location separate to where the services were located. Their time was split between there and the service locations. Some staff said that the absence of managers was an issue at some locations.

Overview of ratings

Our ratings for Northwick Park Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Minor injuries unit						
Medical care	Requires improvement	Inadequate	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement
Specialist burns and plastic services						
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Neonatal services						
Services for children and young people	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	N/A	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Overview of ratings

Our ratings for Ealing Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Minor injuries unit						
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Specialist burns and plastic services						
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology						
Neonatal services						
Services for children and young people	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Overview of ratings

Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community End of Life care	Good	Requires improvement	Good	Good	Good	Good
Community Children YP and families	Requires improvement	Good	Good	Good	Good	Good
Community Adult services	Good	Good	Good	Good	Requires improvement	Good
Community Inpatient services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Community dental services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Our ratings for London North West Healthcare NHS Trust

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

Notes

Outstanding practice and areas for improvement

Outstanding practice

- We saw several areas of good practice or progress including:
- a newly opened emergency department at Northwick Park
- a good service overall for end of life care particularly at Ealing and in the community health service.
- a refurbished and child friendly ward for children's care called Jack's Place.
- caring attitudes, dedication and good multi-disciplinary teamwork of clinical staff.
- good partnership working between urgent and emergency care staff and London Ambulance staff.
- good induction training for junior doctors.
- research projects into falls bundles, stroke trials and good cross site working in research.
- Staff told us there were good opportunities for training and career development.
- We found the specialist palliative care team (SPCT) to be passionate about ensuring patients and people close to them received safe, effective and good quality care in a timely manner.
- The play specialists in services for children demonstrated how they could make a difference to the service and its environment in meeting the needs of the children and young people. This included an outstanding diversional therapy approach for children and young people, which was led by the play specialist and school tutor.
- evidence of good antibiotic stewardship, particularly at Ealing pharmacy, with regular reviews of need; and the roll out of drug cabinets across certain parts of the trust with secure finger print access.
- patient satisfaction data collected by iPAD in one pharmacy location
- an increase in pharmacy cover at one community unit (Denham) enabling reduced medicines related risks.
- The availability and input of dedicated psychologists as part of the multidisciplinary team at the Willesden Centre for Health and Care provided patients with improved long term outcomes.
- The virtual ward operating in the Harrow community, with input from clinicians based at Northwick Park Hospital, supported patients who have long term chronic conditions to stay in their own homes and reduce hospital admissions.

Areas for improvement

Action the trust MUST take to improve

- **To satisfy the requirements of the Section 29A warning notice issued:**
- Ensure appropriate medical staffing and competency of staff in the Elective High Dependency Unit (eHDU)
- Ensure reportable incidents are reported in Surgical services
- Ensure appropriate staffing competency out of hours in radiology
- **To satisfy the Requirement notices issued:**
- Review and improve its Duty of Candour response to moderate harm.
- Review and raise its checks and practices to the necessary standard under Fit and Proper Persons (FPPR) requirements for existing and future senior staff.

For Ealing Hospital:

- Instigate and continue an improvement plan in the emergency department to achieve mandatory targets including the 4 hour treatment target.
- Set an action plan to address poor performance against College of Emergency Medicine audit measures on pain relief, renal colic, fractured neck of femur and consultant sign off.
- Improve mandatory training levels and support for all staff to reach trust targets of 95%.
- Ensure COSHH assessments and arrangements are up to date and maintained.
- Ensure staff receive training and have their knowledge assessed in Mental Capacity and Deprivation of Liberty safeguards.

Outstanding practice and areas for improvement

- Review infection prevention and control (IPC) practice and ensure correct IPC dress protocols are observed for all staff.
- Ensure patients' nutrition and hydration is monitored with fully completed records on medical wards.
- Improve record keeping with respect to fluid balance charts.
- Review IPC and improve cleanliness of equipment and fixtures on Ealing medical wards.
- Improve hand hygiene to show audits resulting in above 90% compliance and leading to 100%.
- Develop care plans which enable individualised information to be reflected and acted upon by staff.
- Improve referral to treatment times in surgery.
- Improve theatre utilisation and efficiencies related to start and finish times.
- Implement WHO patient safety checklists in all surgery settings
- Formally define care pathways in surgery.
- Improve provision of equipment for surgery.
- Ensure improvement in data completeness for patients having major bowel cancer surgery in line with the England average of 87% and up from the hospital performance of 30%.
- Review the surgical environment with respect to the needs of individuals living with dementia.
- Improve ventilation in the endoscopy department.
- Set up a formal escalation process for deteriorating patients on eHDU.
- Ensure all eHDU handovers are consultant led.
- Implement a hospital wide training programme to ensure ward staff understanding of end of life care and the Last Days of Life Care Agreement (LDLCA).
- Improve signage for patients in outpatient clinics.
- Review all arrangements and processes for the care and treatment of children at Ealing ED.
- Take steps to examine and improve staff morale on Ealing medical wards.
- Review drug round timings to minimise medicines errors
- Review therapy visits on wards to prevent and minimise patients missing therapy.
- Review and improve facilities for patients living with dementia and remove inconsistencies of care.
- Address items on the OPD risk register including lack of capacity, lack of complete medical records, overbooking of clinics, and the absence of a plaster sink in the plaster room.
- Review medicines temperature control issues across all locations where medicines are stored.
- **For Northwick Park Hospital:**
- Improve consultant cover on eHDU to include out of hours and weekend working
- Provide consultant radiologist support at weekends to ensure accuracy of clinical diagnosis.
- Ensure all medical and nursing staff are reporting all reportable incidents on Datix.
- Improve access to services and patients flow through the ED at Northwick Park to wards on the hospital.
- Set in place a recovery plan to improve performance and consistently meet national 4 hour waiting targets in ED.
- Set an action plan to address poor performance against College of Emergency Medicine audit measures on pain relief, renal colic, fractured neck of femur and consultant sign off.
- Improve mandatory training levels and support for all staff to reach trust targets of 95%.
- Ensure staff receive training and have their knowledge assessed in Mental Capacity and Deprivation of Liberty safeguards.
- Review infection prevention and control (IPC) practice and ensure correct IPC dress protocols are observed for all staff.
- Improve hand hygiene to show audits resulting in above 90% compliance and leading to 100%.
- Monitor required checks and cleaning of equipment including epidural trolleys.
- Improve the environment of the stroke wards at Northwich Park Hospital.
- Ensure improvements in handovers between ED and the wards at Northwick Park with clarity including MRSA screening and medicines management.
- Ensure patients' nutrition and hydration is monitored with fully completed records on medical wards including Malnutrition and Universal Scoring Tools (MUST).
- Improve record keeping with respect to fluid balance charts.
- Review drug round timings to minimise medicines errors.
- Review therapy visits on wards to prevent and minimise patients missing therapy.

Outstanding practice and areas for improvement

- Ensure improvement in data completeness for patients having major bowel cancer surgery in line with the England average of 87% and up from the hospital performance of 30%.
- Review and improve the post-operative environment in which children recover following surgery.
- Review service level agreements related to the provision of surgical instruments.
- Provide sufficient trained and experienced medical and nursing cover on eHDU at all times including out of hours and at weekends to ensure immediate availability on the unit.
- Set up a formal escalation process for deteriorating patients on eHDU.
- Ensure all eHDU handovers are consultant led.
- Ensure medical care on eHDU follows Faculty of Intensive Care Medicine guidelines.
- In maternity and gynaecology address safety concerns in relation to midwife shortages, lack of safety thermometers displayed and pressures on single staff covering more than one area, for example triage and observations simultaneously.
- Review the maternity risk register to include missing issues such as lack of soundproofing in the bereavement room.
- Implement a hospital wide training programme to ensure ward staff understanding of end of life care and the Last Days of Life Care Agreement (LDLCA).
- Improve signage for patients in outpatient clinics.
- Address items on the OPD risk register including lack of capacity, lack of complete medical records, and overbooking of clinics.
- Ensure incidents in OPD are reported, escalated, investigated with learning derived and shared.
- Review and improve consultant cover in haematology .
- Improve facilities in the haematology day care clinic.
- Ensure adequate emergency evacuation procedures in outpatients and diagnostic imaging (OPD)
- Ensure that blood testing results for patients on anti-coagulant medications are made known to patients and their GP's without delay and to protect them from the risk associated with known medication side effects.
- **For all community services:**
  - Take action to ensure community staff are integrated and feel part of the organisation.
  - Ensure all staff working within the community health services receive adequate training.
- **For community end of life care:**
- Develop an end of life link nurse or champion role within each community team to raise awareness of end of life issues and act as a resource for the team.
- Provide mandatory EOLC training for all nurses across all three boroughs to promote equity of knowledge, not only in syringe drivers and symptom control, but also in the understanding of the Gold Standards Framework and recognitions of the deteriorating patient at end of life.
  - **For children's and young people and families community services:**
- Take action to reduce caseloads of staff in health visiting and paediatric therapy services.
- Ensure robust protocols are in place for the transfer of necessary communication between midwifery and health visiting services.
- **For adult community services:**
- Ensure all staff working within the adult community health services receive adequate training.
- Harmonise adults community health services and systems used across various locations to ensure continuity and allow for shared learning from complaints and incidents across the organisation.
- Develop a workforce strategy and business development plans to ensure adults community health services are not reliant on use of temporary staff.
- Ensure prompt access to adults community health services including tissue viability service, speech and language therapy and continence services among others.
- Engage staff in the community adults health services development and reconfiguration so they can influence changes within the organisation.
- **For community inpatient services:**
- Ensure that the Denham Unit has sufficient nursing staff to keep patients safe at all times.
- Increase the number of full time registered nurses and decrease the number of bank and agency nurses.
- Ensure patients with memory need are identified and they receive personalised care according to their needs.

Outstanding practice and areas for improvement

- Develop a single vision and set of operating procedures across the three community hospitals.
- **For community dental services:**
- Ensure the secure storage of all patient records at all service locations.
- Set up a system to ensure that nitrous oxide and oxygen cylinders are taken out of use once they have passed their expiry date.
- Ensure that mandatory training for staff is up to date.
- Ensure consistent availability and use of computers and software across all service locations
- Ensure that risks are managed appropriately and in a timely manner.
- Ensure clear communication channels between trust-level managers and the service and ensure that service managers are able to provide adequate support to staff at all locations.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour 20(2)(3)(4)(a-d)(6) Notifications in person and in writing have not been provided to the relevant person for some incidents triggering the duty or recorded: • The Trust's reports on DoC requested by the CCG (A) showed that, contrary to the Trust's DoC guidance to maintain full written documentation of any meetings, there was no evidence that verbal notifications had been provided for the following serious incidents: ▪ 15/50 in August at Ealing and associated sites ▪ 11/14 in August at Northwick Park and associated sites ▪ 4/12 in September at Northwick Park and associated sites ▪ We did not request the September Ealing summary figures • Incidents resulting in moderate harm were not included in three of the four DoC reports above • Upon detailed review of 7 incidents (B) in Datix and related patient notes and, in some cases, clinic notes, we found no evidence of: ▪ a verbal notification made in 5 of the 7 ▪ a written notification made in 3 of the 7 • Incidents resulting in psychological harm are not mentioned within the Trust's 'Incidents and Near

Requirement notices

Misses policy', February 2015, which includes the Duty of Candour (DoC) policy and procedure at Appendix H, nor in any other guidance or prompts for staff we saw (C)

20(3)(d)(e)(4)(d)(6) Verbal and written apologies to the relevant person have not been recorded for all incidents triggering the duty:

- Whilst staff within the services / wards told us they had a good understanding of the requirements of the duty, nurses from Northwick Park Hospital told us in focus groups they did not know that the notification in person must include an apology.

We saw this direction was included in an Aide Memoire issued to staff in September 2015 but was not included in Datix prompts. There were only prompts for staff within Datix and these did not fully reflect the Trust's DoC policy and procedure (D)

Item

Point

Source

(A)

The Trust had produced 4 reports to the CCG about DoC reporting April to September for

- Ealing and associated sites
- NPH and associated sites

No verbal notifications for

- 15/50 Ealing Aug (SI s only)
- 11/14 NPH Aug (SI s only). 19 in total, 14 of which I think are DoC-applicable. 7 are listed as 'DoC - yes'
- Ealing September (mod/SI)
- 4/12 NPH September (SI s only)

Can not assess third report for DoC but I asked staff member not to produce it as had already taken up time

- Ealing data – all SI s, April to August
- SI DoC status record on Datix – NPH, April to August
- No title – mod/SI s – breakdown by service – to Sept

This section is primarily information for the provider

Requirement notices

- No title – all SI s – NPH – July to Sept

(B)

Detailed review of 7 incidents by inspector and staff together as follows:

Incident number

Incident date

85902

8/5/15

88542

9/4/15

87241

19/6/15

87631

30/6/15

54945

4/5/15

16034

30/6/15

84946

9/4/15

Verbal notifications:

- 4/7 none
- 1/7 none recorded on Datix. Staff member unable to open patient notes for review

Written notifications:

- 2/7 none
- 1/7 none recorded on Datix. Staff member unable to open patient notes for review
- 4/7 yes – good letters
- The Trust selected the first 6 of these incidents for review from a wider sample we requested of incidents to which DoC applied

This section is primarily information for the provider

Requirement notices

- The 7th incident was selected by inspectors from a sample we had produced of incidents previously reported by the Trust to STEIS and NRLS to which DoC applied

Inspector reviewed these incidents on:

- Datix
- Patient notes
- Clinic notes where suggested by staff

(C)

'Psychological harm' omitted from

- DoC policy and guidance
- Aide Memoire

'Incidents and Near Misses policy' February 2015, which includes the DoC policy and procedure

Aide Memoire on DoC, Sept 2015

(D)

Datix prompts were for:

- Has the patient been 'informed' (does not say verbal or written; does not say apology)
- Has an explanation been given
- Click for guidance – goes to intranet page

"There are no other DoC prompts"

Review of Datix with member of Trust staff

Regulated activity	Regulation
	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors Regulation 5 (6) (3) (a) (b) (c) The provider has not taken all reasonable steps to ensure that all nominated individuals are: (a) of good character (b) has the necessary qualifications, skill and experience to properly supervise the management of the carrying out of regulated activities

This section is primarily information for the provider

Requirement notices

(c) are able by reason of their health, after reasonable adjustments are made, of properly doing so.

We reviewed twelve sets of executive or non-executive personnel files. 3 of the twelve files had evidence of FPPR checks and gaps were found in these. 3 files had evidence of DBS checks. One file had director and insolvency checks. On this basis the trust was not compliant with FPPR requirements.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
This notice is served under Section 29A of the Health and Social Care Act 2008. **This warning notice serves to notify you that the Care Quality Commission has formed the view that the quality of health care provided by London North West Healthcare NHS Trust for the regulated activities above requires significant improvement.** The Commission has formed its view on the basis of its findings in respect of the healthcare being delivered in accordance with the above Regulated Activities at the location identified below: Northwick Park Hospital Watford Road Harrow Middlesex HA1 3UJ **The reasons for the Commission's view that the quality of health care you provide requires significant improvement are as follows:** • You do not have the appropriate medical staffing or competency of staff of the Elective High Dependency Unit (eHDU). • You are not reporting adverse incidents in your surgical services. • You do not have appropriate staffing competency out of hours in radiology. **Significant improvements are required in relation to the quality of the health care provided by the trust in relation to the regulated activities set out in this Notice, by way of having effective systems in place that address the points numbered 1 to 3 above.** • You do not have the appropriate medical staffing or competency of staff of the Elective High Dependency Unit (eHDU). • The eHDU was set up as a postoperative care unit which would not be subject to the same requirements	Significant improvements are required in relation to the quality of the health care provided by the trust in the regulated activities set out in this Notice, by way of the Trust ensuring that care and treatment is provided in a safe way for critical care service users, through the provision of such services by sufficient numbers of appropriately qualified, competent, skilled and experienced staff. **You are required to make the significant improvements identified above regarding the quality of healthcare by 7 January 2016.**

as a critical care unit. However information obtained during our inspection and provided by the hospital in November 2015 such as the Elective High Dependency Unit Operational Policy indicates surgical patients can be admitted as a 'step-down' from the Intensive Therapy Unit or from any other unit in the hospital providing the patient has a surgical pathway, even if the patient has not been to theatre. This information demonstrates the eHDU is used as a high dependency unit rather than as a post-operative care unit and so is subject to the relevant critical care requirements.

- Information provided by the hospital in November 2015 indicates none of the consultants currently or since the eHDU opened responsible for patients within eHDU have Faculty of Intensive Care Medicine accreditation. This is not compliant with recommendations from the Faculty of Intensive Care Medicine Core Standards which state "care must be led by a consultant in intensive care medicine" and is not appropriate medical staffing as it places patients at risk of receiving suboptimal medical care and treatment.
- Out of hours medical cover is provided by the on-call anaesthetic registrar who is also responsible for emergency theatre cases, with telephone support from the on-call anaesthetic consultant. Information provided by staff during our inspection detailed the busy workload of the on-call registrar which meant the eHDU frequently had no doctor present on the unit. This is not compliant with recommendations from the Faculty of Intensive Care Medicine Core Standards which state "There must be immediate access to a practitioner who is skilled with advanced airway techniques" and is not appropriate for the patient cohort cared for on the unit. Patients are at risk of harm due to lack of immediate medical cover available in the event of sudden deterioration.
- You are not reporting adverse incidents in your surgical services.
- During our inspection visit to the theatre department at Northwick Park Hospital on 20 October 2015 we were made aware of two patient-related incidents which had occurred that day. The first was of a patient not receiving the required pre-operative preparation. The second was of another patient whose consent had not been completed fully to take into account the need for two surgical procedures.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

- At the request of consultant surgeons, we met on 22 October 2015 with six consultants and two other doctors. We were informed by the consultants in this discussion that formal reports for adverse events were not always completed. They said the reasons for this was they found the forms were too laborious and because of the failure to action matters reported previously.
- During our formal discussions with the surgical directorate leads on Friday 23 October 2015 we requested a report from the Datix system of incidents reported on or after 20 October 2015 inclusive of 23 October 2015. The information was provided later on the same day of 23 October 2015, and we found neither of the two incidents which occurred on 20 October 2015 had been reported on the Datix system.
- We reviewed a serious incident report, dated 28 July 2015, which pertained to an incident that occurred on 9 April 2015 ref (2015 25470).The incident related to the mixing up of two female patients investigative pathology. This had resulted in one of these individuals having an unnecessary and radical appearance altering operation at another hospital. This serious incident which the trust informed us they had sought and received advice that it did not meet the criteria for a never event, was nevertheless preventable. Had preventative measures been implemented, it would not have occurred.
- Minutes of the Joint Surgical and Anaesthetic Morbidity and Mortality Meeting held on 29 September 2015 contained evidence indicative that incidents had not always been reported. Minutes stated that all radiology addendum reports that had an effect on a patient's outcome needed to be entered on to Datix and highlighted in order to be logged as evidence. We noted that two patients with delayed diagnosis due to misdiagnosis on initial CT should have been included as evidence for discussion with radiology regarding addendums.
- You do not have appropriate staffing competency out of hours in radiology.
- In our discussion with the aforementioned medical staff on 22 October 2015, they reported lack of consultant radiology cover at weekends. They

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

informed us this had contributed to patients missed pathologies. This has resulted that, in place of consultant staff without requisite experience and skills have continued to review patient scans.