

# Imperial College Healthcare NHS Trust Hammersmith Hospitals

## Quality Report

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

## Ratings

Medical care (including older people's care)

**Requires improvement**



# Summary of findings

## Letter from the Chief Inspector of Hospitals

Imperial College Healthcare NHS Trust provides acute and specialist healthcare for a population of around two million people in north west London and the surrounding areas. The trust has five hospitals Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and the Western Eye. Charing Cross Hospital is an acute general teaching hospital located in Hammersmith, London.

Medicine and specialist medicine at Hammersmith Hospital sat under two directorates in the hospital; with the majority of the medical wards under the division of medicine and integrated care. The medical services include including renal, haematology, cancer and cardiology care and provides a regional specialist heart attack centre.

We plan our inspections based on our assessment of the risk to patients from care that is or appears to be less than good. We inspected the medicine and elderly care services because we had information giving us concerns about the quality of this service.

We last inspected the medicine and elderly care service in September 2014 as part of our comprehensive inspection program and rated the service as requires improvement. During that inspection we observed hospital discharges occurring after 10pm. We found that care plans for people living with dementia and diabetes were not used and we noted patients stayed in the hospital for longer than the national average. There were high vacancy rates among staff and it was not clear what the senior management was doing to address this.

During this inspection we found the overall quality of the medicine and elderly care services had stayed the same, but there were some positive changes. The service was rated as requires improvement. We rated safe and responsive as requires improvement, and we rated effective, caring, and well-led as good.

Our key findings were as follows:

- Signage on site was poor and therefore, there were many visitors and members of the public lost and wondering how to get to their desired location.
- We found the environment on some wards was poor. Staff submitted requests for repairs but the work took a long time to be carried out. Some wards had identified the areas requiring repair as a potential infection prevention and control risk in their risk registers. Staff on one ward told us they had been able to make some changes, which improved patient observation but the environment remained on the directorate risk register.
- The trust was not monitoring compliance with the Faculty of Medicine's Core Standards for Pain Management Guideline (2015).
- Liquid medicines on two wards did not have a date recorded for when they were opened. One of those medicines was used to relieve severe pain and should be used within 90 days of opening. Staff were not following the trust's policy, which stated that the date of opening should be recorded. Ten boxes of medicines and fluids for intravenous administration were out of date on one ward. The expiry date of one medicine was nine months before our inspection.
- The results of the national diabetes audit showed patient experience was rated below the national average and the rate of foot assessments was worse than other services.
- Patients could not access the patient advice and liaison service at Hammersmith Hospital. The service was advertised as being available but the office was closed and the telephone number provided was not manned.
- Some cardiac patients were not able to access cardiac rehabilitation because the service did not have adequate capacity.

# Summary of findings

- Some patients experienced delays in receiving their chemotherapy medicines. Staff told us about one patient whose chemotherapy infusion could not be fully administered because it had exceeded the time period in which the medicine was effective. There were problems preparing some medicines on the Hammersmith site and these were being transferred from another site in the trust.
- Staff told us patient transport between sites was a problem and patients were unhappy about the length of time they waited for transport between sites and for going home after treatment.
- Staff told us executive directors did not often visit the site. The Chief Executive had met with senior staff to discuss the trust's strategy. They said they valued receiving information because major changes were taking place, which affected the hospital.

However,

- The service managed patient safety incidents well. Staff received feedback from incidents they had reported. Learning from incidents was included in a staff bulletin, which was circulated to staff in the medicine and integrated care division.
- Results of patient safety monitoring were displayed on ward noticeboards for patients and visitors.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- Patients' records were mostly electronic and staff described the benefits of medical staff being able to review test results or prescriptions from anywhere in the trust. Some wards were liaising with social services via email as part of planning patients' discharge.
- Services participated in a wide range of national audits and benchmarked performance against other hospitals.
- Staff followed clinical guidelines and pathways, which were up to date and accessible on the trust's intranet.
- Patients' needs were planned and reviewed by multidisciplinary teams. Care of the elderly consultants worked with cardiology, renal and cardiac colleagues to plan the care provided to older patients.
- Governance arrangements were robust and had been revised to take account of recent changes in the management structure.
- The provider was working with commissioners and partners to plan services, which met the needs of the local population in Hammersmith and Fulham.
- Renal and haematology patients could contact the service day or night to discuss their symptoms and any care, which might be required.
- Patients with cardiac symptoms could access services at a new heart attack centre dedicated to provide specialist investigation and treatment.
- The complaints service was reviewed, resulting in improvements to the quality and timeliness of responses.
- Nurse managers described how services were co-ordinated and managed within the new multi-site divisional structure. They told us there was a site manager with responsibility for the operational co-ordination of services on the hospital site and between sites.

There were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

# Summary of findings

- The trust must ensure all wards and departments follow the trust's medicine management policies so that medicines are safe for administration to patients. In particular for date checking medicines and storing medicines in refrigerators.
- The trust must improve the proportion of medical staff completing mandatory training, level 2 adult safeguarding training in particular.

In addition the trust should:

- The trust should ensure patients and carers have the same access to the trust's PALs service as patients on other sites.
- The trust should ensure the cardiac catheter lab complies with the World Health Organisation (WHO) safer surgery checklist.
- The trust should develop plans for addressing problems with the preparation of oncology treatments at the Hammersmith site and ensure staff and patients are informed. The trusts should also monitor the number of treatments adversely affected by delays in providing oncology medicines.
- The trust should clarify and implement a pathway for access to Level 2 beds for Haematology patients
- The trust should support clinicians and managers to develop the planned investigation unit and to review how specialty medicine beds and wards were configured across the site.
- The trust should improve signage and the environment on the wards by addressing the backlog maintenance programme.
- The trust should improve the provision of cardiac rehabilitation services.
- The trust should ensure patients with diabetes are able to access foot care.
- The trust should ensure all staff particularly those caring for older people fully understand and follow the requirements of the Mental Capacity Act (2005).
- The trust should ensure adequate overnight SHO rota cover for clinical haematology.
- The trust should review the recording of patients' own controlled drugs to make sure stock levels and administration can be clearly documented.

**Professor Ted Baker**  
**Chief Inspector of Hospitals**

# Hammersmith Hospitals

## Detailed findings

### Services we looked at

Medical care (including older people's care)

# Detailed findings

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## Background to Hammersmith Hospitals

Imperial College Healthcare NHS Trust is based in north west London, United Kingdom. The trust was formed in October 2007. It is a large trust registered with the CQC for 12 location, five of which are hospitals. The trust together with Imperial College London forms an academic health science centre. For the period of November 2015 to October 2016 there were 95,538 admissions trust wide for the medical core service, with the majority of admissions being day cases. Trust wide the top three specialties in the medical core service by activity were; medical oncology, gastroenterology and clinical haematology. The average length of stay in the mentioned period was 6.7 days.

Hammersmith Hospital, formerly the Military Orthopaedic Hospital, and later the Special Surgical Hospital, is an acute general teaching hospital located in west London. The present hospital was founded in 1912 and is part of Imperial College Healthcare NHS Trust. There are 16 medical wards these include: haematology, renal, cardiology, gastroenterology and infectious diseases wards. Care for elderly patients is provided on John Humphrey specialist medical ward and C8, a cardiology ward. A heart attack assessment unit, endoscopy day unit, renal dialysis and chemotherapy day care units are also based on the site. Christopher Booth ward is a planned medical investigation unit for endocrinology and gastroenterology patients and has 16 gastroenterology inpatient beds.

The trust had 95,538 medical admissions between November 2015 and October 2016. Emergency admissions accounted for 24,836 (26.0 %), 6,565 (6.9 %) were elective, and the remaining 64,137 (67.1 %) were day case. Admissions for the top three medical specialties were; Medical Oncology (18,794 admissions), Gastroenterology (14,722 admissions) and Clinical Haematology (14,427 admissions). There was a total of 35722 inpatient medical admissions to Hammersmith Hospital between April 2016 and March 2017, 29390 of these were elective admissions and 6332 were emergency admissions. The majority of emergency admissions were to cardiology with 2552 admissions, followed by nephrology with 2023 admissions. The largest number of planned admissions were in haematology.

We visited a total of 17 wards and departments including wards A7 and A8 cardiology wards, the heart attack assessment unit, C8 cardiology, cardiothoracic and care of the elderly ward. We also visited the Constance Wood chemotherapy day unit, haematology day unit, Auchin dialysis unit, Christopher Booth planned investigation unit and John Humphrey infectious diseases ward.

# Detailed findings

## Our inspection team

Our inspection team was led by:

Inspection Manager: Michelle Gibney, Care Quality Commission

The team included CQC inspectors and a variety of specialists including consultants of varying medical professions, senior and junior medical nurses, nurse matron, pharmacist, governance lead and an Expert by Experience.

## How we carried out this inspection

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

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




We carried out this inspection as an unannounced focused inspection. We carried out the unannounced inspection on 7, 8 and 9 March 2017. Before visiting, we reviewed a range of information we held about the hospital. During the inspection we talked with a range of staff throughout the medical core service, including senior managers, clinicians, nurses, healthcare assistants, administrative staff and volunteers. We also spoke with patients and relatives of those who used the medical core service.

## Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Overall	N/A	N/A	N/A	N/A	N/A	N/A

# Medical care (including older people's care)

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

## Information about the service

Hammersmith Hospital is a specialist hospital with strong research connections. It offers a range of services, including renal, haematology, cancer and cardiology care and provides a regional specialist heart attack centre.

There was a total of 35722 inpatient medical admissions to Hammersmith Hospital between April 2016 and March 2017, 29390 of these were elective admissions and 6332 were emergency admissions. The majority of emergency admissions were to cardiology with 2552 admissions, followed by nephrology with 2023 admissions. The largest number of planned admissions were in haematology.

There are sixteen medical wards located at the Hammersmith Hospital of Imperial College Healthcare Trust. These include: haematology, renal, cardiology, gastroenterology and infectious diseases wards. Care for elderly patients is provided on John Humphrey specialist medical ward and C8, a cardiology ward. A heart attack assessment unit, endoscopy day unit, renal dialysis and chemotherapy day care units are also based on the site. Christopher Booth ward is a planned medical investigation unit for endocrinology and gastroenterology patients and has 16 gastroenterology inpatient beds.

Hammersmith Hospital has undertaken a major development programme during 2016 and now provides a range of highly specialised medical services. Acute, general medical services are no longer provided at Hammersmith Hospital. The acute medical assessment unit closed in August 2016. Patients requiring acute

medical assessment are seen at the St Mary's or Charing Cross sites. Patients seen at either of these sites with a cardiac condition are transferred to Hammersmith Hospital for procedures such as the insertion of a pacemaker.

Renal and haematology patients known to the specialised medical services based at Hammersmith Hospital can contact the service if they had concerns about their condition. The service assesses patients over the phone and they are seen in the triage unit, which has been developed in preparation for the closure of the medical assessment unit.

A chemotherapy day care unit, located in the Catherine Lewis Centre, provides courses of chemotherapy for patients who are well enough to return home the same day following treatment. Some patients attend the centre over several days to complete their treatment cycle.

A renal dialysis unit is located in the Auchin unit on the ground floor of the renal unit. Patients attend the unit sometimes several times a week for dialysis.

A heart attack assessment centre assesses patients taken to the Hammersmith Hospital by ambulance with symptoms of a heart attack.

A renal rapid assessment unit is open between 9am and 6pm during the week and between 10am and 2pm on Saturdays. GPs and staff in outpatients could refer patients to the centre for assessment.

We visited a total of 17 wards and departments including wards A7 and A9 cardiology wards, the heart attack assessment unit, C8 cardiology, cardiothoracic and care



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of the elderly ward. We also visited the Constance Wood chemotherapy day unit, haematology day unit, Auchin dialysis unit, Christopher Booth planned investigation unit and the John Humphrey infectious diseases ward.

We last inspected the service in December 2014 and rated the service as requires improvement. We found medicines storage and management arrangements were not always in line with trust policies. We found that staffing levels were not always adequate and shifts on some wards were not covered in order to meet patients' care and treatment needs.

We told the trust they should improve the management of medicines on the medical wards, ensure patients' records are always appropriately completed and the learning from investigations of patient falls and pressure ulcers was proactively shared trust wide. We also asked the trust to reduce the high number of out-of-hours transfers and discharges.

At this inspection, we found improvements in the storage and management of medicines had not been fully addressed. We found staffing levels had improved. The number of discharges out of hours is being monitored as a result of complaints made by patients.

## Summary of findings

We rated this service as requires improvement because:

- Signage on site was poor and therefore, there were many visitors and members of the public lost and wondering how to get to their desired location.
- We found the environment on some wards was poor. Staff submitted requests for repairs but the work took a long time to be carried out. Some wards had identified the areas requiring repair as a potential infection prevention and control risk in their risk registers. Staff on one ward told us they had been able to make some changes, which improved patient observation but the environment remained on the directorate risk register.
- The trust was not monitoring compliance with the Faculty of Medicine's Core Standards for Pain Management Guideline (2015).
- Liquid medicines on two wards did not have a date recorded for when they were opened. One of those medicines was used to relieve severe pain and should be used within 90 days of opening. Staff were not following the trust's policy, which stated that the date of opening should be recorded. Ten boxes of medicines and fluids for intravenous administration were out of date on one ward. The expiry date of one medicine was nine months before our inspection.
- The results of the national diabetes audit showed patient experience was rated below the national average and the rate of foot assessments was worse than other services.
- Patients could not access the patient advice and liaison service at Hammersmith Hospital. The service was advertised as being available but the office was closed and the telephone number provided was not manned.
- Some cardiac patients were not able to access cardiac rehabilitation because the service did not have adequate capacity.
- Some patients experienced delays in receiving their chemotherapy medicines. Staff told us about one patient whose chemotherapy infusion could not be

# Medical care (including older people's care)

fully administered because it had exceeded the time period in which the medicine was effective. There were problems preparing some medicines on the Hammersmith site and these were being transferred from another site in the trust.

- Staff told us patient transport between sites was a problem. They told us patients were unhappy about the length of time they waited for transport between sites and for going home after treatment. The trust told us patients who attended as day cases or for tests and investigations sometimes had to wait for test results or to be reviewed by medical staff before they could be sent home.
- Staff told us executive directors did not often visit the site. The Chief Executive had met with senior staff to discuss the trust's strategy. They said they valued receiving information because major changes were taking place, which affected the hospital.

However,

- The service managed patient safety incidents well. Staff received feedback from incidents they had reported. Learning from incidents was included in a staff bulletin, which was circulated to staff in the medicine and integrated care division.
- Results of patient safety monitoring were displayed on ward noticeboards for patients and visitors.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- Patients' records were mostly electronic and staff described the benefits of medical staff being able to review test results or prescriptions from anywhere in the trust. Some wards were liaising with social services via email as part of planning patients' discharge.
- Services participated in a wide range of national audits and benchmarked performance against other hospitals.
- Staff followed clinical guidelines and pathways, which were up to date and accessible on the trust's intranet.

- Patients' needs were planned and reviewed by multidisciplinary teams. Care of the elderly consultants worked with cardiology, renal and cardiac colleagues to plan the care provided to older patients.
- Governance arrangements were robust and had been revised to take account of recent changes in the management structure.
- The provider was working with commissioners and partners to plan services, which met the needs of the local population in Hammersmith and Fulham.
- Renal and haematology patients could contact the service day or night to discuss their symptoms and any care, which might be required.
- Patients with cardiac symptoms could access services at a new heart attack centre dedicated to provide specialist investigation and treatment.
- The complaints service was reviewed, resulting in improvements to the quality and timeliness of responses.
- Nurse managers described how services were co-ordinated and managed within the new multi-site divisional structure. They told us there was a site manager with responsibility for the operational co-ordination of services on the hospital site and between sites.

# Medical care (including older people's care)

## Are medical care services safe?

Requires improvement 

We rated safe as requires improvement because:

- The provision of harm free care across all wards was good in the majority of areas but when we looked at the incident records for some wards in more detail, we found higher than expected number of falls and pressure ulcers,. The trust told us one elderly patient had fallen on a number of occasions but they had taken all the necessary steps to reduce the risk of falls.
- The results of hand hygiene audits carried out by the trust showed inconsistent practice. Hand washing rates fell to 73% on Handfield Jones ward in December 2016, 90% on Kerr ward in September 2016 and 73% on the endoscopy unit in December 2016. The rates from November 2016 to February 2017 were consistently below 90% in endoscopy (81% in November, 73% in December, 86% in January and 83% in February). Hand washing compliance on Peters ward ranged from 66% in May 2016 to 95% in February 2017.
- We found the environment on some wards was poor. Staff on ward A7 told us they had been able to make some changes, which improved patient observation, but the environment remained on the directorate risk register.
- Mandatory training rates for medical staff was significantly lower than the trust's 90% target.
- Compliance with level two adult safeguarding training was notably below the trust's target for example only 67% of consultants in specialty medicine and 69% of consultants in cardiac services were up to date with this module of the trust's mandatory training programme.
- We found liquid medicines on two wards where the date of opening was not recorded. One of those medicines was used to relieve severe pain and should be used within 90 days of opening. We found more than 10 boxes of medicines and fluids for intravenous administration, which were out of date on John Humphrey ward.
- Compliance with the World Health Organisation (WHO) surgical checklist in the catheter lab was audited and the results showed compliance with main aspects of the checklist was poor. The directorate had arranged for additional training to be provided.
- The number of incidents on John Humphrey ward in particular. There were 182 reported incidents for John Humphrey ward between December 2016 and March 2017. The ward provided care for the elderly. The majority of incidents, 147 (81%) resulted in no or low harm to patients. Four incidents resulted in moderate harm. These were falls and pressure ulcers. The incidents reported included 51 falls, 16 staff shortages and 30 hospital acquired pressure ulcers. The ward accessed specialist advice and support from the trust's tissue viability service. The division was monitoring the number of pressure ulcers and provided training and support to reduce them.

However,

- The service managed patient safety incidents well. Staff recognised incidents and reported them. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- In February 2017, 13.2% of nursing posts were vacant at Hammersmith Hospital, which was less than the vacancy rates at other sites within the trust. In the same month, 109.3 WTE shifts were filled by bank and agency staff. The trust filled between 94% and 98% of shifts for registered nurses during the day and between 97% and 99% at night.
- The results of the NHS Safety Thermometer information was on display on all the wards we visited. The information was used for monitoring the level of harm free care provided and analyse patient harms. The number of pressure ulcers, venous thromboembolism (VTE) and falls were monitored. The results showed most wards provided high levels of harm free care.
- More than 95% of patients admitted to medical wards across all sites in the trust were assessed for VTE risk within 24 hours of admission to the hospital.
- Nursing staff used national early warning scores (NEWS) to identify if a patient's condition had deteriorated. Staff provided care in line with the National Institute of Health and Care Excellence (NICE) Guideline (CG50) for deteriorating patients.

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- We checked the cleanliness of clinical equipment and found the majority was clean. 'I am clean' stickers were attached to items of equipment, which had been cleaned, ready for use.
- There was good support for the wards from pharmacy. A pharmacist visited the ward twice daily to screen prescriptions and process discharge prescriptions.
- The trust audited compliance with the World Health Organisation (WHO) surgical checklist for endoscopy monthly. The results of the trust wide audit showed compliance levels between 95% and 100% for all elements of the checklist between April 2016 and March 2017

## Incidents

- Staff reported incidents using the online incident reporting system. A lead investigator looked into the incidents and provided feedback to staff. Staff told us they were happy to report clinical incidents and issues such as staffing shortages.
- Between January 2016 and December 2016, the trust reported no incidents which were classified as Never Events for Medicine. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- There were 1556 reported incidents for all medical wards at Hammersmith Hospital between January 2016 and February 2017. Of those, 26 incidents resulted in moderate harm. These included two complications of treatment, five hospital acquired pressure ulcers, three hospital acquired cross infections, seven falls, three device failures, failure to identify a deteriorating patient, medicines and blood transfusion errors. One incident on 5 January 2016 on Peter's Ward caused severe harm where failure to follow guidelines resulted in one patient dying. The incident was investigated. The investigation included 'root cause analysis', the lessons learned were identified and changes implemented and monitored to prevent a similar incident occurring again.
- There were 46 serious incidents in 2016 that occurred in the division of medicine and integrated care. 16 of the 46 serious incidents related to Hammersmith Hospital for that period. Of these, the most common types of incident reported were pressure ulcers and falls meeting serious incident criteria. Serious incidents in health care

are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.

- The care of patients who died or whose condition deteriorated were reviewed by the service in line with best practice. The trust provided us with information about 170 cases reviewed since September 2016. Review meetings were held to discuss the care of the patient and staff were informed about learning and modified guidance or processes. We saw key learning points were identified, for example the importance of clarifying patient wishes prior to inter-hospital transfers.
- Learning from incident reviews was included in the weekly staff information briefing, which was circulated to all staff within the medicine and integrated care division.
- We looked in more detail at incidents on a sample of wards. There were 182 reported incidents for John Humphrey ward at Hammersmith Hospital between December 2016 and March 2017. The ward provided care for the elderly. The majority of incidents, 147 (81%) resulted in no or low harm to patients. Four incidents resulted in moderate harm. These were falls and pressure ulcers. The incidents reported included 51 falls, 16 staff shortages and 30 hospital acquired pressure ulcers. The ward accessed specialist advice and support from the trust's tissue viability service. The division was monitoring the number of pressure ulcers and provided training and support to reduce them.
- There were 195 incidents reported on Fraser Gamble, a haematology ward. Of these, 170 (87%) resulted in no or low harm, One incident resulted in moderate harm when a patient was given the wrong blood transfusion. The incident was investigated and staff were reminded of the importance of following the trust's policies, which required checks to be carried out at each stage of the process.
- There were 104 incidents on ward C8. Of these, 92 incidents (88%) resulted in no or low harm, the remainder were near misses.
- Nursing staff were able to provide examples of learning from incidents and changes to clinical practice, which were implemented as result of incidents being reviewed. The results of investigations into individual incidents

# Medical care (including older people's care)

and trends were discussed at ward and departmental meetings. We looked at incidents on particular wards to see if there were any trends or patterns. The majority of incidents were falls and pressure ulcers.

- Staff we spoke with were aware of the Duty of Candour and the requirement to be open and transparent with people who used services and the processes the trust followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

## Safety thermometer

- The trust supplied us with NHS Safety Thermometer information and we saw examples of this information on display on wards. The NHS Patient Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This enables measurement of the proportion of patients that were kept 'harm free' from pressure ulcers, falls, urinary tract infections (in patients with a catheter) and venous thromboembolism (VTE).
- The results across all wards showed most wards provided harm free care. For example Fraser Gamble, a haematology ward, achieved harm free care between March 2016 and March 2017 for pressure ulcers. Christopher Booth ward provided harm free care between March and November 2016 for pressure ulcers, but between December 2016 and February 2017, this dropped to 92%. Handfield Jones ward provided harm free care for pressure ulcers from January to March 2017, but the figure was between 90% and 95% between April and December 2016. However, the number of pressure ulcers and falls were higher than expected when we examined the incident records in more detail.
- Staff told us they had good support from the tissue viability link nurses to keep pressure sores to a minimum. There was a VTE lead allocated for the trust. More than 95% of patients admitted to medical wards across all sites in the trust were assessed for VTE risk within 24 hours of admission to the hospital. The rates of harm free care were monitored and reviewed by the medicine and integrated care safety committee where actions were agreed to address any increase in the level of harm, for example by providing awareness training for staff on the factors contributing to the development of pressure ulcers.

## Cleanliness, infection control and hygiene

- We checked the cleanliness of clinical equipment on all the wards we inspected and found the majority was clean. We found some infusion pumps on John Humphrey ward, which did not have 'I am clean' stickers attached. These are used to indicate items of equipment which had been cleaned, ready for use.
- We observed staff following good hand hygiene practice and the results of weekly audits were displayed on all the wards we inspected. Hand washing basins were available in bays and treatment areas and there were hand sanitisers available at the entrance to all wards.
- The results of hand hygiene audits carried out by the trust were variable. The results of the handwashing audit for the period April 2016 to February 2017 showed 100% compliance for some wards. However, we saw handwashing rates fell to 73% on Handfield Jones ward in December 2016, 90% on Kerr ward in September 2016 and 73% on the endoscopy unit in December 2016. The rates from November 2016 to February 2017 were consistently below 90% in endoscopy (81% in November, 73% in December, 86% in January and 83% in February). Hand washing compliance on Peter's ward ranged from 66% in May 2016 to 95% in February 2017.
- Personal protective equipment (PPE), for example gloves and aprons, was available in all the locations we inspected and we saw staff used these to reduce the risk of spreading infections. Ward managers told us they inspected ward cleanliness every week with the cleaning manager.
- Incident information provided by the trust showed there were two MRSA cases on Weston Ward and Christopher Booth ward in May and November 2016.
- The endoscopy department were following the guidance set out in Health Technical Memorandum 01-06 for the decontamination of flexible endoscopes.

## Environment and equipment

- We found the environment on some wards was poor. Staff on A7 told us they had been able to make some changes, which improved patient observation, but the environment remained on the directorate risk register.
- However, equipment on John Humphrey ward did not have up to date electrical safety checks. We found infusion pumps, which had not been checked since 2015.

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- There were effective arrangements in place for managing waste and clinical specimens, which kept people safe. This included processes for segregation, storage, labelling, handling and disposal of waste.
- Pressure relieving mattresses were available for patients with pressure sores or who were at risk of developing pressure sores.
- The trust's internal 'ward accreditation programme' process (WAP) identified concerns on ward A7 about cleanliness and the state of repair. Issues such as shelving, floor repairs, locks and painting were highlighted. Staff told us they had requested repairs in December 2016, which had not been carried out. For instance, there was no lock on the dirty utility room, there was red tape on parts of the floor covering holes in the flooring and bare plaster on parts of the walls, where they had been filled but not painted. The cardiac service risk register showed that ward A7 had failed its ward accreditation twice due to cleaning and the state of the ward estate. The flooring was old and needed replacement, doorframes were damaged and required replacement and the ward required repainting. Cleaning frequencies were increased but the repair work had not been carried out. The leadership team highlighted their concerns on the risk register and the estates managers acknowledged there was a backlog of repairs, which required completion. They told us there was a programme in place for carrying out the repairs. They told us the age of the building meant there was a large programme of repairs required.
- We saw cleaning materials that were not locked away, for example floor cleaner. The lock on the cleaning cupboard was broken and had not been repaired.

## Medicines

- The hospital pharmacy service was open from 9am until 7pm between Monday and Friday and for five hours on Saturdays and Sundays. There was an on call pharmacist available outside these hours.
- We inspected the arrangements for managing medicines on four wards. We found there was good support for the wards from pharmacy. A pharmacist visited wards twice daily to clinically screen prescriptions and process discharge prescriptions. The wards received a once weekly top-up service. Ward staff used a pharmacy communication book for leaving messages for pharmacy staff when they visited. Staff told us there were no issues about discharge prescriptions, which were usually available for patients when they were going home.
- Incidents such as medicines errors were reported on the trust's incident reporting system. A ward manager gave an example of a medicine incident where an omitted dose of insulin was not recorded correctly on the electronic record. The ward manager investigated the incident and learning was shared at the monthly ward meeting. The directorates circulated weekly messages that included shared learning about medicine incidents.
- Medicines were kept in locked treatment rooms secured with either keys or key pads on the door.
- We found liquid medicines on two wards where the date of opening was not recorded. One of those medicines was used to relieve severe pain and should be used within 90 days of opening. When we spoke with the ward manager, they told us the trust's policy was that the date should be recorded.
- Records showed that the temperature of the room where medicines were stored was consistently above 25°C for the past year on Christopher Booth ward. This meant some medicines were not always being stored according to the manufacturers' instructions. The trust's policy stated that medicines could be stored up to 30°C. The chief pharmacist was aware that room temperatures were frequently warm but the risk was not included on the pharmacy risk register. We also saw records of fridge temperatures, which showed the maximum recorded was 10 to 13°C in March 2017 but the temperature was retaken two hours later and was then within the recommended range of 2 to 8°C. This was in line with the trust's policy for the management of medicines. We saw evidence of stock being destroyed in December 2016 when the fridge had remained out of range for a prolonged period, which meant staff were aware this was good practice as specified in the trust's medicines policy.
- We checked the storage of controlled drugs and found these were being stored appropriately. We carried out random stock checks on two wards, which showed balances were correct. A registered nurse held the controlled drug keys at all times and kept them separately from the main medicines cupboard keys. Two registered nurses checked the administration process with two signatures recorded in the controlled drug

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register. Nursing staff checked the stock levels of controlled drugs daily, which were recorded in the register. However, the controlled drugs register did not allow clear recording of medicines patients had brought with them into hospital. This meant records of patients' own controlled drugs could not easily be audited.

- We saw that patients' prescriptions were written clearly and included the patient's allergy status.
- Some trolleys on John Humphrey and Christopher Booth wards, where emergency medicine and equipment was stored did not have tamper-proof seals. However, other wards had trolleys that were sealed. We saw records of checks on medicines stock stored on the trolleys that were carried out daily. Managers told us, when they ordered new trolleys, these were lockable.
- Two oxygen cylinders on one ward were in date. However, the regulators, the equipment attached to the cylinders were overdue for reconditioning. One was due in December 2014, the other in March 2015.
- We found more than 10 boxes of medicines and fluids for intravenous administration, which were out of date on John Humphrey ward. The expiry date of one medicine was nine months before our inspection. When we spoke with the ward manager and chief pharmacist about this, they told us it was the responsibility of pharmacy to date check items supplied by pharmacy. Some fluids were delivered directly to the ward, where nursing staff were responsible for checking the dates on those fluids. When we spoke to the nurse in charge, they removed all out of date stock from the shelves and ward staff checked all shelves to ensure all out of date medicines were removed. We also found a medicine in the ward cupboard; the patient had gone home and the medicine should have been returned to the patient or the pharmacist who would dispose of it. We found multiple loose strips of tablets in cupboards, which the trust policy did not permit.
- The trust had a structure of medicine governance and safety meetings, which included a drug and therapeutics committee and a new drugs panel, which reviewed the introduction of new drugs and considered the impact and implementation of NICE guidance. There was a medication safety group, which analysed incidents involving medicines. There was an antibiotic review group, chemotherapy and intrathecal medicine group, non-medical prescribing and patient group,

direction group and quality and safety group. These groups met every four to six weeks and fed into the trust's medicine optimisation committee, which met every four months.

- Pharmacists were involved in the arrangements for patients' discharge; for example, pharmacists checked discharge prescriptions. Pharmacists also assessed patients who required aids to help them take their medicines. They also liaised with patients' local community pharmacy to ensure timely supply of further compliance aids, for example dosette boxes. The pharmacy team intervened in 60% of discharge prescriptions. This was good evidence that pharmacy were contributing to the quality of the discharge process.
- There was a roaming pharmacy discharge team, whose role involved speeding up the discharge process for patients by ensuring they received the medicines required to take home.
- When we visited the chemotherapy unit, staff told us they were experiencing delays in receiving patients' chemotherapy medicines. There were problems with the preparation area at Hammersmith Hospital and some medicines were prepared and transported from another site in the trust. Staff told us this had led to a delay in commencing one patient's treatment, as they had not been able to receive all of their planned treatment because the effectiveness of the drug had expired due to the length of time it took from receipt to completing administration. There were plans to centralise the preparation of chemotherapy medicines in the trust. Staff said they supported the change but in the meantime, they remained concerned about unexpected delays, which disrupted the care patients received.

## Records

- The trust had moved to an electronic patient records system in April 2016. Records were audited as part of the trust's harm free care monitoring.
- Care plans and information about the care patients received was recorded using an electronic clinical information system the trust had recently introduced. Staff we spoke with were positive about the system and provided examples of how the use of the system had improved patient care. For example, medical staff could prescribe a patient's medicines from a computer anywhere in the trust after checking the patient's

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records on line. Staff told us the majority of patients' records were now held on line. We reviewed five electronic patient records and found these contained care plans, which included pain assessments, nursing observations, food and fluid charts. Care plans also included falls assessments, information about visual and hearing difficulties, pressure ulcer care plans and plans for patients' nutritional needs.

## Safeguarding

- Nursing staff we spoke with told us they all had completed level two training for safeguarding adults. However, staff on John Humphrey ward, which provided care to older people, were unsure about the things they should look out for as signs of abuse. They were aware of the risk of physical abuse, but less sure about the signs of other forms of abuse such as psychological abuse. Patients identified as being at risk, including children on the child protection register were flagged on the trust's patient information system. Staff knew how to access support and advice about safeguarding concerns and how to contact the safeguarding team.
- Within the specialist medicine directorate, 67% of consultants, 78.2% of qualified nurses and 100% of unqualified nurses had completed level two adult safeguarding training. The trust's target was 90%. Compliance rates for level two safeguarding children training were 89% for consultants, 83% for qualified nurses and 100% for unqualified nurses. All doctors in training had completed level two safeguarding children training. Level one safeguarding adult and level one safeguarding children training had been completed by 40% of admin and clerical staff. The divisional management team had identified that the level of training needed to be improved and additional training courses were being organised.
- Within renal services, 95% of qualified nurses and 100% of unqualified nurses had completed level two adult safeguarding training. Compliance rates for level two safeguarding children training were 95% for qualified nursing staff and 100% for unqualified nursing staff. Level one safeguarding adult and level one safeguarding children training had been completed by 100% of admin and clerical staff.
- Within cardiac services, 69% of consultants, 68% of career grade doctors, 92% of qualified nurses and 100% of unqualified nurses had completed level two adult safeguarding training. Compliance rates for level two

safeguarding children training were 66% for consultants, 100% for career grade doctors, 92% for qualified and 9% for unqualified nurses. Level one safeguarding adult and level one safeguarding children training had been completed by 65% and 60% of admin and clerical staff.

- Within clinical haematology, 86% of consultants, 100% of career grade doctors, 70% of doctors in training, 96% of qualified nurses and 100% of unqualified nurses had completed level two adult safeguarding training. Compliance rates for level two safeguarding children training were 83% for consultants, 100% for career grade doctors, 71% for doctors in training, 90% for qualified nurses and 100% for unqualified nurses. Level one safeguarding adult and level one safeguarding children training had been completed by 65% and 61% of admin and clerical staff.

## Mandatory training

- Nursing staff showed us how they accessed their training accounts on the trust's training system. The system reminded their managers when training updates were due. Staff we spoke with were up to date with their mandatory training. One member of staff showed us their training records and we saw they had completed all the modules of their mandatory training. A manager also showed us their monitoring report, which showed the trust's target of 90% compliance was achieved for the staff they managed.
- We noted that electronic medicines administration training was suspended. Managers told us this training module was being reviewed and was suspended until the new training was available. The trust told us face to face training was available for staff.
- Mandatory training compliance rates for consultants were below trust target of 90%, ranging from 48% (oncology consultants) to 81% (renal consultants). Compliance rates for doctors in training ranged between 58% (oncology trainees) and 95% (cardiac trainees). Additional training was being organised in specialties where the training rates were below the trust's target for training.
- The trust's mandatory training programme covered conflict resolution, fire safety, equality and diversity, safeguarding adults and children, infection prevention and control, health and safety, information governance, moving and handling.



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- Mandatory training compliance rates were 90% for registered cardiac nurses, 91% for haematology nurses, 88% for renal nurses and 82% for specialist medical nurses.
- Mandatory training compliance rates were 87% for unqualified cardiac nurses, 95% for haematology nurses, 86 % for renal nurses and 78% for specialist medical nurses.
- New staff completed an induction programme when they joined the trust, which included all mandatory training topics.

## Assessing and responding to patient risk

- The trust audited compliance with the World Health Organisation (WHO) safer surgery checklist for endoscopy monthly. The results of the trust wide audit showed compliance rates between 95% and 100% for all elements of the checklist between April 2016 and March 2017.
- There were processes in place for patients on admission and admitted and patients identified as having sepsis or at risk of developing sepsis were monitoring during their inpatient stay. We saw that a sepsis toolkit to identify patient's risk of developing sepsis.
- The cardiac risk register contained a risk for completion of the WHO checklist in catheter lab. Compliance with the WHO checklist was audited and the results showed compliance with main aspects of WHO checklist was poor. The directorate had arranged for additional training to be provided.
- We saw nursing staff used a five-step model for pressure ulcer prevention (SSKIN). We saw examples of five electronic patient records, which contained information about the risk of developing pressure ulcers. Nurses who specialised in maintaining tissue viability assessed patients at risk of developing pressure ulcers. We saw examples of assessments, which had been completed and the results of regular skin inspections, which were recorded in patients' records.
- John Humphrey ward had 11 care of the elderly beds and 10 beds for patients with infectious diseases. There were nine side rooms for caring for patients with infectious diseases. The rooms were equipped with negative pressure ventilation system, which meant possibly contaminated air from the rooms did not flow into the main ward area. During our inspection, a haematology patient was admitted, as there was no bed available on haematology or renal wards. Nursing staff

told us patients from other specialties were assessed if they were suitable for being cared for on this ward and renal or haematology medical staff reviewed these patients. However, some staff did not feel they had the appropriate skills and experience to care for patients with complex haematological conditions.

- Nursing staff used a national early warning score (NEWS) to identify if a patient's condition had deteriorated. We observed nursing staff checking patients in a timely way depending on the results of the nursing observations carried out. We reviewed the information recorded in six patients' assessments and found these had been completed correctly. Staff provided care in line with the National Institute of Health and Care Excellence (NICE) Guideline (CG50).
- In April 2016, the trust moved to an electronic patient record system, which enabled continuous monitoring of failure to rescue. Failure to rescue refers to death after a treatable complication. The rate of failure to rescue patients derived from routine administrative data is recognised as an important indicator of patient safety. Monthly harm free care reports included failure to rescue information, which was reviewed by divisions in their Quality and Safety meetings and in relation to establishment reviews.

## Nursing staffing

- There were 486.7 whole time equivalent (WTE) qualified nursing posts and 98.1 unqualified nurses posts at Hammersmith Hospital in February 2017.
- In February 2017, 13.2% of nursing posts were vacant at Hammersmith Hospital, which was less than the vacancy rates at other sites within the trust. The turnover rate for staff in the 12 months prior to February 2017 was 13.1%. The sickness absence rate was 3.9%. There were 109.3 WTE posts filled by bank and agency staff during the month of February 2017.
- There were particular challenges in filling nursing posts in haematology. The service had developed a number of measures aimed at improving the situation, for example, talent-spotting nurses from other areas of the trust to work in haematology and professional development leading to internal promotion opportunities. The service also provided post-registration training and extended practice, for example: chemotherapy modules, apheresis, vascular access and prescribing.

# Medical care (including older people's care)

- We saw the trust policy for the provision of safe nurse staffing and skill mix. The policy highlighted the responsibility of registered nurses to ensure safe practice, including staffing and ensure that risk was managed appropriately. The trust's policy was based on National Institute for Health and Care Excellence (2014) guidelines, which provides recommendations on safe staffing for nursing in adult inpatient wards in acute hospitals, based on the best available evidence.
- Nurse staffing levels were based on the safer staffing model. The service used an evidence-based tool that enabled nurses to assess patient acuity and dependency, identifying the staffing required ensuring that nursing establishments reflected patient needs.
- The trust's policy set out individual responsibilities for ensuring effective staffing levels. Ward sisters and matrons were responsible for highlighting, managing and escalating staffing risks in accordance with the Trust's Risk Management Policy (2015). The site operations team were responsible for deploying and allocating staffing out of hours between sites if necessary and authorising the use of agency staff to maintain patient safety. The policy specified the ratio of registered to unregistered nursing staffing should not fall below 65:35. The ratio of registered nurses to patients would not fall below 1:8 during the day.
- The trust used the 'Safe Care' acuity and dependency tool (endorsed by NICE in 2015) within the staff electronic roster system for planning nurse staffing levels. This included a measure of patient dependency based on the recommendations of the Association of UK University Hospitals (AUKUH) adult/acuity dependency tool.
- Acuity and dependency data was inputted into the tool twice a day in each ward area, which calculated the amount of nursing time, required per patient throughout a 24-hour period for each ward. Managers monitored staffing levels and patients' needs daily. The information was presented as a dashboard showing when staffing levels were appropriate or represented a risk. Managers re-deployed staff and authorised the use of bank or agency staff based on the information presented on the dashboards. The information system also enabled managers to monitor staffing levels against clinical risks and incidents, for example pressure ulcers, falls and inability to deliver their activities of daily living.
- We attended two nursing staff handover meetings and found there was a comprehensive assessment of patients' conditions. Each member of staff had a printed list of patients for recording relevant information about what had happened during the night and anything that would affect the patient's care that day, for example if the physiotherapist was due to visit a patient. Staff discussed risks and concerns related to patients' mobility, pressure areas, pain, continence and nutrition. Staff handing over and staff newly on shift discussed individual patients in more detail at the bedside where they checked the patients' medicines, vital signs and changes to the NEWS status.
- On the day of our inspection, there was one unfilled shift on De Warender ward, a level two care ward, which was filled with an agency nurse. The staff rotas showed there were two agency staff on duty most nights. Renal medicine staff were able to access nurses who worked for the trust's nursing bank. Nursing staff told us site managers supported the unit to ensure transplants were not cancelled because of a lack of staff to care for patients following surgery.
- Fill rates for nursing staff shifts on medical wards for the period November 2016 to February 2017 ranged from 94% to 98% for registered nurses, 83% to 90% for care staff during the day, from 97% to 99% for registered nurses at night and 94% to 98.4% for care staff.
- Fill rates for nursing staff shifts on cardiac wards for the period November 2016 to February 2017 ranged from 97% to 98% for registered nurses, 85% to 92% for care staff during the day, 99% for registered nurses at night and 86% to 97% for care staff.
- The appraisal rate for nurses was 88% against a trust target of 90%.
- We saw the results of the friends and family survey included comments from seven patients about improving staffing levels on John Humphrey ward.

## Medical staffing

- The trust provided us with the number of doctors based at the Hammersmith Hospital in February 2017. There were 2.5 WTE trust grade doctors, 80 consultants and 143.6 doctors in training.
- In February 2017, 5.3% of medical staff posts were vacant, which was the lowest number of vacancies for medical staff in the trust. Medical staff turnover rates were 0.6%, which were lower than the other two hospitals in the trust. Sickness rates were 0.3% in February 2017, similar to the other hospitals in the trust. Medical staff absences and vacancies were covered by

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227 hours of locum cover, which equated to 1.4 whole time members of staff. The majority of cover was provided in rheumatology, gastroenterology and endocrinology. There was one consultant vacancy in gastroenterology, which was covered by a locum.

- The cardiac risk register referred to the lack of medical staff for the heart attack centre, which opened in August 2016 as part of the programme of change for medicine at Hammersmith Hospital. Initially, locum medical staff provided cover for the ward. The service planned to use advanced nurse practitioners (ANP) who required up to one year training. The risk register was updated in February 2017 and showed the ANP's were in place although they still required training. They were covering the ward every day, supported by locum junior doctors until they were fully trained.
- We spoke with medical staff from the renal service who expressed concerns about medical staffing levels. Renal medical staff we spoke with told us the ratio of medical staff to patients meant medical staff were working more clinical sessions than agreed in their job plan. There were concerns about staff being able to sustain the number of sessions worked. The trust told us they were in the process of appointing four more consultants.
- We saw a risk included in the haematology risk register concerning the impact of medical services being restructured. The number of medical junior doctors at Hammersmith Hospital had been reduced by three. However, one post was created reducing the gap to two. Following our inspection the trust provided with additional information which shows the staff rotas were changed to ensure there was adequate cover. The risk had an initial risk score of 20 (high risk) but had been reduced to two following the arrangement of temporary cover.

## Major incident awareness and training

- Staff were familiar with the content of the major incident plan for Hammersmith Hospital. The major incident plan, which was updated annually, included contact information for key staff and described the arrangements for organising and managing the trust's response including allocating staff, liaising with emergency services and with the other sites within the trust.
- The trust had a business continuity plan that was updated regularly. The continuity plan had actions in place for staff to refer to in the event of the impact of any

of these risks. We saw that staff were compliant with their major incident and business continuity training; staff were all trained between October 2016 and February 2017.

- There was a trust major incident policy that was available to all staff via the hospital intranet and we observed that most wards had printed copies available at the nursing stations.

## Are medical care services effective?

Good



We rated effective as good because:

- Services participated in national audits and benchmarked performance against other hospitals.
- Staff followed clinical guidelines and pathways, which were up to date and accessible on the trust's intranet.
- Patients' nutritional needs were assessed and staff accessed a dietitian's advice if required.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other national services. We saw evidence where the service was performing better than national average
- Cardiology and care of the elderly staff worked together to care for older patients on wards C8 and A7 with daily consultant rounds and twice-weekly multidisciplinary meetings where the care of individual patients was discussed. Cardiology outpatient clinics specialising in the care for older patients were also in place.
- We saw a wide range of information leaflets provided on wards about clinical conditions and the support arrangements for patients.

However:

- The results of the national diabetes audit showed patient experience was rated below the national average and the rate of foot assessments was worse than other services.
- The trust was not checking if services were following the Faculty of Medicine's pain management guideline.

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- Although all staff completed their MCA and DoLS training, the staff we spoke with whilst on inspection were inconsistent in their understanding of MCA and DoLS.
- Some patients experienced delays in receiving their chemotherapy medicines, which meant that they had to wait for their medicines. Staff told us about one patient whose chemotherapy infusion could not be fully administered because it had exceeded the time period in which the medicine was effective. There were problems preparing some medicines on the Hammersmith site and these were being transferred from another site in the trust.

## Evidence-based care and treatment

- Staff provided care in line with the National Institute of Health and Care Excellence (NICE) Guideline - CG50 - that covers recognising and responding to deteriorating patients. Staff used a national early warning score (NEWS) to identify deteriorating patients so they were escalated to the medical team or critical care outreach team (CCOT) appropriately.
  - The trust used the results of local and national audits to benchmark and review the care provided against the guidance produced by nationally recognised bodies such as the National Institute for Health and Care Excellence (NICE) and professional bodies including the Royal College of Physicians.
  - Staff accessed clinical guidelines using the trust's intranet and were able to show us recent guidelines they had accessed for their speciality, which included for example, acute coronary syndrome.
  - An audit of haematological cancers completed in October 2016 showed reasonable assurance that the service complied with national standards for haematological cancers.
  - An audit of compliance against NICE guidelines for dying patients and use of end of life care pathways was planned for 2016 but was overdue.
  - An adult asthma audit had been completed in 2016 but was not yet published.
  - We reviewed the trust's policies staff used for delivering care on the wards and found these were all reviewed and updated to include the most recent clinical guidelines.
  - The outcome of audits was reported to the monthly directorate quality and safety committees.
- The hospital had a process for reviewing clinical guidelines, which ensured their current practice reflected relevant national guidelines, policies or research. A policy and guidelines committee reviewed policies and guidelines and ensured these reflected the most up to date guidance.
  - The endoscopy service used the clinical standards defined by the Joint Advisory Group (JAG) developed by the Academy of Medical Royal Colleges. The standards applied to the practice of individual endoscopists, training in endoscopy and a quality assurance scheme for endoscopy units. The endoscopy unit at Hammersmith Hospital was externally reviewed in November 2016 as part of the JAG accreditation scheme and found to be fully compliant with the standards.
  - We saw the results of an audit of endoscopy decontamination using Infection Prevention Society (IPS) guidelines carried out in June 2016. The audit showed the service was compliant with all 167 standards reviewed. Five areas were identified where action was required to improve practice, for example, occupational chemical exposure limits were not recorded and there was no recognised training lead. The trust had developed an action plan for addressing the issues highlighted.

## Pain relief

- The trust told us performance against the Faculty of Medicine's Core Standards for Pain Management Guideline (2015) had not been audited.
- The trust did not complete ward level or trust level audits of pain score assessments. This meant it was difficult to be assured that pain score assessments were being completed effectively. We saw examples of pain assessments which nursing staff had carried out recorded in patients' records.
- An acute and chronic pain team was available 24-hours, seven days a week. The Trust's Pain management service was a multidisciplinary team involving anaesthetists with training in pain medicine, nurses, including nurse prescribers, psychologists and physiotherapists. The service also had dedicated pharmacy support. Staff were able to gain advice from the pain service or refer patients to the service.

## Nutrition and hydration

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- Patients received a nutritional assessment on admission and staff could access a dietitian's advice if clinically required. We saw examples of nutritional assessments completed in patients' records.
- Patients' nutritional needs were monitored by staff using the Malnutrition Universal Screening Tool (MUST) as recommended by the British Association for Parental and Enteral Nutrition. Nurses used the tool to assess whether patients were at risk of dehydration, poor nutrition or swallowing difficulty. We saw staff recorded patients' food and fluid intake as part of monitoring a patient's condition.
- Dietary supplements were provided for patients who were experiencing difficulty maintaining an adequate dietary intake.
- Patients who had swallowing difficulties were referred to speech and language therapists (SALT).
- Most wards had protected meal times for patients, which were displayed on the ward. Protected mealtimes allowed patients to eat their meals without unnecessary interruption and ensured staff were able to focus on providing assistance to those who needed it.
- Staff wore suitable personal protective equipment (PPE) when serving food and checked the temperature of food before serving.
- We saw that all patients on the wards had access to fresh water.

## Patient outcomes

- The trust reported outcomes from all national mandatory audits as they were published via the trust's quality report, which was presented to executive quality committee and trust level quality committee.
- The service participated in a wide range of national audits: Myocardial Ischaemia National Audit Project (MINAP) for cardiology patients, Coronary Angioplasty, National Audit of Percutaneous Coronary Interventions (PCI), National Heart Failure, Cardiac Rhythm Management Devices, Cardiac Rhythm Management Devices 2017, Inflammatory Bowel Disease Programme (IBDP), National Oesophago-gastric cancer, End of Life Care Audit: Dying in Hospital, National Comparative

Audit of Blood Transfusion programme: The 2016 audit of red cell and platelet transfusion in adult haematology patients, Renal Replacement Therapy (Renal Registry) and the National Diabetes Inpatient audits.

- The most recent Latest Myocardial Ischaemia National Audit Project (MINAP) for cardiology patients report published in February 2017 for the period April 2015 to March 2016 demonstrated 100% participation rates.
- There were clinical leads for each of the national clinical audits the trust were involved with, to oversee the data submitted and review the trust's performance in comparison to other similar services elsewhere in the country. Leads were responsible for completing the action and submitting the evidence to the corporate safety and effectiveness team who monitored that all actions identified were addressed. The Clinical Audit and Effectiveness Group was established in the Autumn of 2016, chaired by a newly appointed clinical lead for audit and effectiveness. The group meets monthly to review, on a rotational basis, national audits, NICE compliance and local audits.
- The results of the 2016 heart failure audit showed that 82.3% of patients who were discharged had been prescribed beta-blockers, 100% had had a discharge plan, 41.5% were referred to a specialist heart failure nurse but only 9.4% of patients were referred for cardiac rehabilitation. The number of patients receiving cardiac rehabilitation was significantly worse than the national average.
- The results of the national Coronary Angioplasty and National Audit of Percutaneous Coronary Interventions (PCI) showed 279 primary PCIs were carried out between June 2015 and June 2016. The hospital's performance was better than the national average for patients admitted directly from the community. The door to balloon time was less than 90 minutes for 94.2% of patients. Call to balloon time for community cases was less than 150 minutes for 86.4% of patients. However, treatment times were worse than national average for patients transferred from other hospitals; 45.5% of patients were seen in less than 90 minutes, call to balloon time was less than 150 minutes for 35.5% of patients. The trust's performance had improved with the delays to treatment reported by those hospitals providing primary PCI for patients admitted directly and those transferred from other hospitals, demonstrated in

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audit results reviewed by us. The trust performed better than national average for prescribing secondary prevention medication for 96.7% of patients compared to 91.5%

- The results of the 2014 to 2015 Cardiac Rhythm Management Devices audit showed that Hammersmith Hospital recorded 95% implant procedures for physiological pacing compared with the national average of 89.4%.
- The results of the 2016 Inflammatory Bowel Disease Programme (IBD) showed the trust had improved in one of the audit criteria and remained the same for the other two criteria when compared to the previous report. The trust had identified a range of actions for improving results, which included a new standard for first line treatment for patients with active IBD and screening all patients prior to receiving biological therapy for active IBD.
- The results of the 2016 National Comparative Audit of Blood Transfusion (NCABT) showed 59% of transfusions were for chronic anaemia, 94% of patients had their haemoglobin measured within 24 hours if they were an inpatient or within 72 hours if they were an outpatient. Single unit transfusions were uncommon with 27% inpatients compared to 13% outpatients. When more than one unit of red cells was transfused only 11% of inpatients and 0.5% of outpatients had a Hb measured in between units.
- The latest results from the national diabetes audit related to the care provided in 2015. The results of the 2016 audit had recently been received by the trust but had not been evaluated by the service lead. The results of the 2015 audit showed that 20% of inpatients had diabetes with above average rates of insulin treatment. The specialist nature of the trust meant there were high numbers of patients being treated for end stage renal failure at Hammersmith Hospital. The audit showed the service was carrying out appropriate glucose testing and appropriate use of IV insulin infusions. Prescribing and management were a challenge across all three sites but rates of hypoglycaemia were similar to other services. Rates of foot assessment were low but comparable with the national average. Patients with active foot disease were not reviewed by the foot team in a timely manner. Patients were unhappy with the choice of meals. Overall patient experience was rated below the national average
- The trust participated in the national dying in hospital audit. The trust performed better (94%) than the national average of 56% for ensuring patients' needs were identified at the end of life and 81% of patient needs were recorded as part of a holistic needs assessment compared with 66% nationally. However, the audit also showed that patients did not always have access to a face-to-face palliative care six days a week, which was one of the national standards.
- The trust participated in the national oesophageal cancer audit which showed the survival rates for patients was 82% after one year, which was better than many other trusts nationally. The results of this audit also showed that the trust was one of only six trusts nationally which achieved 100% for providing patients with a management plan for high-grade dysplasia over the three years of the audit from 2012 to 2015.
- Between October 2015 and September 2016, patients at Hammersmith Hospital had a similar-to-expected risk of readmission for non-elective admissions and a lower expected risk for elective admissions when compared to the England average. In both cases, cardiology reported a higher risk of readmission than expected, while the other top two specialities reported a lower risk. The re-admission rate for Hammersmith Hospital was 5.2% for the period from September 2016 to February 2017, compared with 5.7% at Charing Cross Hospital and 6.7% at St Mary's Hospital. The highest rate of re-admission was 7% in December 2016, the lowest rate was 1.3% in September 2016.
- Some patients experienced delays in receiving their chemotherapy medicines, could adversely affect the outcome of their treatment. Staff told us about one patient whose chemotherapy infusion could not be fully administered because it had exceeded the time period in which the medicine was effective. There were problems preparing some medicines on the Hammersmith site and these were being transferred from another site in the trust.
- We noted that the trust was consistently monitoring and improving their mortality rate and remained in the top five lowest-risk acute trust. The trust was the second lowest-risk acute trust in the 2016 Hospital Standardised Mortality Ratio (HSMR) and the third lowest-risk acute trust in the Summary Hospital-level Mortality Indicator (SHMI).

## Competent staff

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- There were practice development teams in haematology and renal services who supported staff development. Cardiovascular services did not have a similar role but had requested funding to establish a post.
- Within the last 12 months, 88% of nurses had received an appraisal, against a trust average of 87.4%. Most of the staff we spoke to in the hospital during the inspection had their appraisal within the last 12 months. The appraisal was on a rolling basis and all staff had their appraisals by the end of the year.
- Appraisal rates for medical staff were 100% in cardiology and nephrology. However, 81% of consultants in haematology and 80% in endocrinology had been appraised.

## Multidisciplinary working

- Multi-disciplinary team meetings (MDTs) were held by all the services we inspected. Some services had meetings twice a week where healthcare professionals met to discuss and co-ordinate patients' care. The MDT meetings included medical, nursing and therapy staff. Social care staff were involved in planning the care of patients with complex needs.
- Care of the elderly consultants attended MDTs on some wards to contribute to discussions about the care provided for older patients.
- Staff told us they accessed support from the trust's advisor for patients with a learning disability. They also contacted the psychiatric liaison team to ensure patients' mental health needs were met.
- Cardiology and care of the elderly staff worked together to care for older patients on wards C8 and A7 with daily consultant rounds and twice-weekly multidisciplinary meetings where the care of individual patients was discussed. Cardiology outpatient clinics specialising in the care for older patients were also in place.
- Pathways were in place for referral between specialities within the hospital and between other hospitals in the trust.
- The service avoided discharging older people late at night if they had complex needs and lived alone. The trust was monitoring the number of occasions when patients were discharged at night following complaints.
- The haematology wards had weekly MDTs and ward reviews. Renal services held monthly multidisciplinary

meetings. Care of the elderly consultants contributed to the joint review of older renal patients, reviewing frail, complex older patients on renal wards and writing chronic kidney disease and frailty guidelines for GPs.

- Patients with complex needs were reviewed by multi-professional teams which included physiotherapy, occupational therapy, nursing, pharmacy and medical staff.
- Medical and nursing staff worked together to assess and plan patient's care and treatment in a timely way when people are due to move between teams or services, including referral, discharge and transition.
- Information about the needs of older people and patients' with complex needs was communicated to members of the community health team on discharge using the trust's electronic patient information system. Ward staff were also able to communicate with social care teams in preparation for patients' discharge.

## Seven-day services

- There was a renal rapid assessment unit, which was open from 9am to 6pm during the week and between 10am and 2pm on Saturdays. GPs and staff in outpatients could refer patients to the assessment centre.
- Imaging and diagnostic services to medical wards was available 24 hours seven days a week. The imaging team and radiologists were available seven days a week for acute medical patients. The nursing and medical staffs told us scans were available in a timely manner when needed and staff reported no issues in accessing imaging or diagnostic services outside of working hours.
- The pharmacy service operated between 9am and 7pm from Monday to Friday and for five hours on Saturday and Sunday. There was a pharmacist on call outside these hours.
- Patients known to the renal and haematology services could contact a triage service, which assessed patients over the phone to determine whether they needed to attend the hospital for treatment. There was a renal assessment unit attached to the Auchin unit.
- The heart attack centre was one of eight across London, which provided specialist 24-hour emergency care and treatment for anyone suspected of having a heart attack in the West London area.

## Access to information

# Medical care (including older people's care)

- Renal and haematology patients had patient passports, which contained important information about their condition. Patients who were concerned about their condition could contact the renal and haematology assessment service for advice.
- Staff accessed the information needed to deliver effective care and treatment using the trust's computer systems. This included information included inpatients electronic records, test results and the trust's clinical policies.
- When patients transferred between services at referral, discharge and transfer information needed for their ongoing care was shared appropriately, in a timely way using the trust's electronic patient information system.
- Discharge information was communicated to GPs electronically within 24 hours after discharge.
- GPs direct access to the heart attack assessment and renal services and could speak to medical staff on the telephone to access advice.
- Patients receiving chemotherapy were given an acute oncology card with information about symptoms to watch out for and how to contact the acute oncology service out of hours.
- We saw a wide range of information leaflets provided on wards about clinical conditions and the support arrangements for patients.

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

- Doctor, nursing and allied health professional staffing groups in the acute and specialist medicine directorate met the trust target of 90% for MCA and DoLS training.
- We found there to be some inconsistency in the level of understanding of MCA and DoLS by medical and nursing staff we spoke with. On one ward, staff were unclear about the law relating to patients with a mental health condition, which meant they were unable to provide consent to care and treatment. Staff told us they would obtain consent from family members if a patient had dementia and was unable to provide consent or they would ask medical staff to assess the patient's mental capacity. We did however, see examples of mental capacity assessments, which had been completed correctly and scanned on to the clinical information system.

- Staff we spoke with on other wards understood the process for obtaining authorisation for a deprivation of liberty in accordance the trust's policy which complied with the requirements of the Mental Capacity Act (2005)
- We spoke with a patient who was due to have a procedure carried out. They told us they had not yet signed their consent form but the doctor had explained the procedure in detail and allowed them to ask questions about what was involved and how they might feel afterwards

## Are medical care services caring?

Good



We rated caring as good because:

- All the patients we spoke with said staff were kind and helpful.
- The results of the friends and family survey showed the majority of patients would recommend the service.
- Psychological and emotional support was available to patients following diagnosis of long-term or life threatening condition. This service extended to offering counselling, consultations with a psychologist or psychiatrist, specialist nurse or consultant.
- A wide range of support groups was available to patients, carers, friends and family.

However:

- Work was required to protect the privacy and dignity of patients attending the endoscopy unit.

## Compassionate care

- Patients we spoke with agreed that they felt safe and well cared for. One patient told us: "The nurses are all so positive. I was quite down when I was diagnosed and have dialysis three times a week. The nurses help me cope."
- We spoke with a carer who attended dialysis with a relative. They told us they were offered lunch and hot drinks and felt they were well looked after. They said they felt their role as a carer was respected and staff were interested in getting to know them.



# Medical care (including older people's care)

- Another patient told us they had transferred to Hammersmith Hospital from another hospital in the trust. They said they preferred the service at Hammersmith Hospital and they wanted to have their care provided there. They said they felt staff were more approachable and they had learned more about their condition by asking questions which staff were happy to answer. They said the only problem with the service was the length of time they waited for transport.
- The most recent JAG review of the endoscopy unit highlighted the need to protect patients' privacy and dignity by covering windows panels.. There were small panel windows in the doors leading to the treatment rooms. Staff told us they had requested the windows to be frosted and were waiting for the work to be completed.
- Staff we spoke with understood and respected the importance of people's personal, cultural, social and religious needs and how they considered these when providing care.
- We observed staff interacting with patients listening to concerns and providing reassurance. One patient we spoke with who was due to have surgery said staff were reassuring. This helped them feel less anxious.
- One person we spoke with cared for their relative at home. They were staying on the ward to help provide care and said staff were welcoming and supportive. They said staff kept them informed and involved them in discussions about their care.
- The hospital used the Friends and Family Test (FFT) to gather patients' views on whether they would recommend the service to family and friends. The Friends and Family Test response rate for Medicine at the trust was 32%, which was better than the England average of 25% between January 2016 and December 2016. The majority of wards achieved scores greater than 90% throughout this period. We looked at the latest trust medical and integrated division scores for January 2017. The results showed that 97% of patients would recommend the service on Christopher Booth ward, 83% on Hadfield Jones ward, 83% on Dacie ward, 96% on A9, 97% on C8 100% on John Humphrey ward, 85% on Peter's ward and 100% on Kerr ward.
- Patients told us they felt involved and encouraged to make decisions about their care from admission to discharge. Patients told us they felt supported and staff gave them appropriate and timely information. They gave several examples where they were provided with information and given time to make decisions about their treatment.
- Staff we spoke with recognised when people who use services and those close to them need additional support to help them understand and be involved in their care and treatment and enable them to access this. This includes language interpreters, sign language interpreters, specialist advice or advocates.
- Medical staff specialising in care of the elderly provided a liaison service to haematology, renal and cardiology services on site and organised meetings with families to discuss their relatives care plan.
- We observed in all areas we visited that there was a wide range of written information authored by the NHS and supporting organisations regarding health conditions and treatment for the patients and their relatives.
- Patients we spoke with told us staff introduced themselves and explained what they were doing before providing care. Patients felt they were given an opportunity to ask questions about any care and felt staff were patient with them.

## Emotional support

- Staff we spoke with demonstrated that they understood the impact that a patient's, treatment or condition would have on their wellbeing and on those close to them, emotionally and socially.
- Psychological and emotional support was available to patients following diagnosis of long-term or life threatening condition. This service extended to offering counselling, consultations with a psychologist or psychiatrist, specialist nurse or consultant. There was a clinical psychology service for cancer patients and staff support in the hospital.
- Patients could access the trust's chaplaincy service for support with spiritual needs.

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

# Medical care (including older people's care)

- Patients we spoke with during the inspection told us staff were attentive and provided them with everything they needed.
- Staff we spoke with displayed good understanding of the impact of the patient's care, treatment or condition on their wellbeing and on the impact on their relatives.
- We observed there were various support groups available to patients, carers, friends and family. For example, the heart support group and support groups for cancer patients. There was a sickle cell service user group, which supported patients to meet together to discuss their condition and treatment.
- We saw information and advice leaflets for patients on topics such as access to benefits, hair loss and about Tai chi classes.

## Are medical care services responsive?

Requires improvement



We rated responsive as requires improvement because:

- Medical specialties referral to treatment time for December 2016 and January 2017 did not achieve the national 92% target.
- Patients could not access the patient advice and liaison service at Hammersmith Hospital. The service was advertised as being available but the office was closed and the telephone number provided was not manned.
- Some cardiac patients were not able to access cardiac rehabilitation because the service did not have adequate capacity.
- Staff told us patient transport was often a problem and patients were unhappy about the length of time they waited for transport for going home after treatment.
- We found that patient discharges were still occurring out of hours. At our previous inspection we found there had been a number of patient complaints due to this. At this inspection we found the trust was continuing to monitor the situation and the number of out of hours discharges had reduced.
- When we visited ward C8 we also found the standards of decoration were poor. A relative told us the lighting, ventilation and decoration was poor. Staff told us some

improvements were made when they first moved to the ward in August 2016 but further work was required. The ward was created to provide care for older patients and patients requiring cardiac surgery.

However:

- The provider was working with commissioners and partners to plan services, which met the needs of the local population in Hammersmith and Fulham.
- Renal and haematology patients could contact the service day or night to discuss their symptoms and any care that might be required.
- A renal home therapy team provided care for patients who were suitable to have treatment at home.
- Staff contacted social services to plan the discharge of patients returning to residential care or who required social care support at home.
- Patients with cardiac symptoms could access services at a new heart attack centre dedicated to provide specialist investigation and treatment.
- The complaints service was reviewed to improve the quality and timeliness of responses.

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

- Patient-centred pathways were being developed in partnership with three other local hospital trusts, the local provider of community services, local authorities, the London Ambulance Service and voluntary organisations. An 'Accountable Care Partnership' was being developed to manage the health and wellbeing of 200,000 people living within the borough of Hammersmith and Fulham. The plans included the care patients received when they accessed services and when they were discharged from hospital. Patients and the public were involved in designing services.
- The cardiac risk register highlighted that over 200 patients had not received cardiac rehabilitation within 10 days of discharge in accordance with NICE guidelines due to access issues. The cardiac rehabilitation service did not have adequate capacity to provide all patients with the rehabilitation they required. A nurse responsible for the programme had developed a plan for expanding the capacity of the service but this was not in place at the time of our inspection.

# Medical care (including older people's care)

- Between November 2015 and October 2016 the average length of stay for medical elective patients at Hammersmith Hospital was 5.3 days, which is higher than England average of 4.1 days. For medical non-elective patients, the average length of stay was 7.1 days, which is higher than England average of 6.7 days. The longest stays were reported in elective clinical haematology (11.8 days) and non-elective nephrology (10.6 days).

## Access and flow

- A new joint triage unit was set up in August 2016 for haematology and renal services, which provided direct access to specialist beds for patients requiring emergency admission. The service operated 24 hours a day, seven days a week. The trust had modelled capacity and demand as part of setting up the new service. The unit was set up to assess patients, initiate treatment within four hours and subsequently admit the patient or discharge them.
- The trust's referral to treatment time (RTT) for admitted pathways for Medicine in December 2016, showed 74.4% of this group of patients were treated within 18 weeks compared with the England average of 90.4%. The trust's performance was similar to the England average in January 2016, but had fallen below it since that time and grown steadily worse between January and December 2016.
- The following specialties were below the England average for admitted RTT percentage within 18 weeks: Cardiology 70% compared to the England average of 84.8%; Gastroenterology 89.7% compared to the England average of 94.5%.
- For the period of December 2016, the two weeks GP referral to the first outpatient appointment for cancer patient was 93% (similar to the England average) and for breast symptoms was 96% (better than England average). The 31 days wait from diagnosis to first treatment for the same period was 97% (higher than the England average of 96%). The trust also scored higher or similar to the England average on 31 days second or subsequent treatment (100%), 62-day urgent GP referral to treatment (82%) and 62 days urgent GP referral to screening (93%).
- The unit treated 1146 patients between August 2016 and February 2017, 45% renal and 55% haematology, 57% of patients were admitted. The service was being monitored to ensure it provided effective access to specialist services for high-risk patients. We saw the operational policy developed to describe how the service should operate. This described the referral process, patient pathway, staffing, clinical management and performance standards for the service. The performance standards included initial assessment of patients by a doctor within 30 minutes of arrival and a treatment plan agreed within four hours of arrival. The service met these standards. The policy required staff to follow NICE guidelines for pain management and sepsis guidance. Compliance with the operational policy was audited by monitoring the care provided and sampling the records held on the clinical information system.
- A number of major changes had taken place in 2016 following a decision to close the acute medical admissions unit. The trust had reviewed the medical care remaining on the Hammersmith Hospital site after 1 August 2016 to ensure the services were provided safely and GPs and ambulance services knew how to help patients access the appropriate care. The specialist medical assessment centre closed and the Single Point of Access for Medicine (SPAM) was relocated to Charing Cross Hospital.
- A new chest pain pathway was developed. Patients were assessed in a new Heart Attack Centre. Patients were transferred from the accident and emergency service at St Mary's and Charing Cross hospitals or received patients with cardiac symptoms directly via the emergency ambulance service.
- Following the transfer of acute medicine away from Hammersmith Hospital, pathways were developed for ensuring patient safety on the wards and for patients and visitors on site, for example in the outpatient department. The pathways, including contact details of staff required in an emergency were available on the trust's intranet. A site practitioner, duty medical registrar and medical emergency team were available 24 hours a day to provide cover if an emergency occurred.
- Patients who received chemotherapy during the day were able to contact the trust's acute oncology service out of hours if they became unwell after leaving the unit. The service provided patients with a wallet sized card, which contained information about when and how patients could access information and advice if they

# Medical care (including older people's care)

developed problems with their condition or the chemotherapy drugs they were receiving. Patients could contact the chemotherapy unit during the day or the acute oncology helpline out of hours and at weekends.

- Infectious disease services were reviewed to ensure services worked effectively across all three sites and staff were able to access the infectious diseases team. The service cared for complex tertiary referral and specialist patient groups. The service aimed to improve the management of infectious diseases. The service reviewed the care of 521 patients to identify where the pathway could be improved. As a result, the patient pathway was developed to include bi-weekly clinical reviews with follow-up in an outpatient setting by the infectious diseases team.
- Staff told us transport services had become particularly important since medical services were re-configured. The number of patients attending for short periods of care and returning home rather than being admitted had increased. These patients required transport home following treatment. Staff told us patients often had to wait for transport. Three patients we spoke with on the dialysis unit told us they sometimes had to wait two hours for transport. They described how frustrating it was to spend most of the day receiving treatment only to have to wait a long time for transport.
- At our previous inspection, we found some patients were being discharged home in the evening. Figures provided by the trust for the month of February 2017 showed three patients were discharged between the hours of 10pm and 7am from endocrinology, 11 from cardiology and 19 from haematology. The trust were monitoring out of hours discharges to reduce the number of occasions patients were discharged out of hours and in response to the number of complaints received. Lessons learned had resulted in reducing the number of discharges out of hours.
- The renal unit cared for patients starting dialysis, encouraging home treatment where this met patients' needs. There was an integrated Home Therapies Team on site who provided peritoneal dialysis and home haemodialysis programmes.
- The Auchincrib dialysis unit was open from 8am in the morning until midnight on weekdays and 10pm on weekends.

- Staff on ward C8 showed us how they communicated with social services departments to inform them when patients were likely to be discharged and when they required social care to resume on their return home. Staff told us this had helped them improve the discharge arrangements for patients.

## Meeting people's individual needs

- Staff told us they accessed support from the trust's advisor on supporting patients with a learning disability or living with dementia to ensure patients' needs were met. Staff also said there was good support from psychiatric liaison team.
- Staff assessed patients with dementia when they were admitted.
- Two nurses' role involved organising patients' discharge from the renal unit.
- Staff told us they were able to ensure patients who required a special diet received the appropriate meals. These included high-energy, soft, gluten free, vegetarian, halal or kosher meals and healthy eating options.
- One issue that frustrated staff and patients was getting timely assistance from porters for those in need of wheelchair assistance. Reception staff called the control room at Charing Cross Hospital, who logged the job and sent it through to the porter's office at Hammersmith Hospital. Staff told us about waiting times of 15 to 30 minutes during which patients became frustrated and late for appointments in outpatients.
- Hammersmith Hospital consisted of a number of buildings, built at different periods, resulting in three different types of signage on display at locations throughout the hospital. As patients and visitors moved from one part of the hospital to another, they also moved between buildings with different signage conventions. We found a number of examples where signs and directions to wards changed or signage directing patients to locations and wards ran out. Therefore, many visitors and members of the public had difficulties finding their desired location. For instance, moving from area B on the first floor to area A (clinical investigations, radiology, appointments, pharmacy, transport, way out, women's health, wards A6, 7, 8 and 9) the signs ran out leaving no further directions to

# Medical care (including older people's care)

destinations when reaching the lift area. There was a smaller sign, in a different font in a smaller size, which showed the area A directory. Reaching the indicated floor for wards A7, 8 and 9, signage was not prominent and was in two different colours. Signage to C8 ran out when we reached the lift area for C block on the ground floor. We asked a nurse for directions who told us it was located on the first floor but not signed. Staff told us they had repeatedly requested changes to signs.

- When we visited ward C8 we found no decorations to make the ward friendly for patients or visitors. A relative told us the lighting, ventilation and decoration was poor. Staff told us some improvements were made when they first moved to the ward in August 2016 but further work was required. The ward was created to provide care for older patients and patients requiring cardiac surgery.

## Learning from complaints and concerns

- A poster in the main entrance (south entrance) stated that the patient advice and liaison service (PALS) was available on site Monday to Friday 9.30am to 5pm located on the ground floor of 'south corridor'. There were no signs along south corridor to state the location of the PALS office. A member of staff told us they knew where the office used to be but they were unsure where it had moved to. Reception staff told us where the service was located but were unsure of the opening times. The PALS office was closed, a sign on the door stated the office would re-open on 9 March at 9.30am with a telephone number to call. We called the number and got through to an answerphone. We spoke to the PALS and complaints managers about access to the service, they told us they had not received many contacts from patients and had reduced the number of hours the service operated.
- The complaints department was reorganised in 2016. A complaints and service improvement manager worked with the clinical divisions and their governance leads on service improvement projects based on complaints. The complaints manager identified the discharge process as an area for improvement based on the number of complaints received, in particular about vulnerable patients sent home without suitable clothing. From March 2016 to February 2017, there were 36 complaints across the trust compared to 27 complaints in the previous year. A number of actions staff needed to take

were identified such as including clothing in the discharge section of the trust's clinical information system, which needed to be completed as part of the discharge process. The trust aimed to reduce the number of complaints to 20 over the next 12 months. The trust planned to offer patients access to a third party clinician to provide mediation for patients and carers during the complaints process. The service was being offered to patients in the medical division as part of a pilot to test whether it would increase the number of complaints resolved at local resolution. Complaints were analysed by clinical divisions rather than hospital sites. The trust monitored the response time for complaints to ensure they were answered in line with the trust's complaints policy. Response times had improved following a review of the complaints department.

- Complainants received support from the patient advice and liaison service (PALS). PALS also helped to arrange meetings with patient and family if requested. Staff were aware of the PALS services and their role in the complaint process. However, staff stated they rarely had any contact with the PALS service or saw them on the wards. Staff stated they would try to handle any concerns that patients had on the ward informally, particularly if they could give the complainant immediate action.
- The trust has employed four band seven complaints investigators 18 months ago to deal with complaints received by the trust. The complaints investigators handled complaints received along with support from the area manager or divisional lead. Senior staff we spoke with stated it had previously been difficult to respond to patients within the target time. However, the introduction of complaints investigators had improved response times and the quality of investigations. The hospital also collected compliments from service users, with a view to examining the data for any themes.
- Patients we spoke with stated they would be confident any complaint they made to the trust would be taken seriously.

# Medical care (including older people's care)

## Are medical care services well-led?

Good



We rated well-led as good because:

- The trust had strategies in place for transforming services through innovation and managing the sustainability of services.
- Strategic change was well managed and staff understood and supported the changes.
- Clinical staff were involved in the development of a programme of clinical strategies and workforce transformation plans to improve the clinical and operational sustainability of services.
- The leadership structure had recently changed at divisional level. Senior clinicians and managers told us the new management teams were developing and spoke positively about the support they had received.
- The service had good arrangements for continually improving the quality of care and promoting high standards. Managers monitored performance and used the results to help improve care. Staff identified risks to good care and the service took action to eliminate or minimise risks.
- The trust was working with partners in the local health community to improve admission and discharge processes.
- Ward staff told us their immediate managers were visible and visited the wards every day to discuss operational issues on the ward.

However:

- Staff told us executive directors did not often visit the Hammersmith site. The Chief Executive had met with senior staff to discuss the trust's strategy. They said they valued the information their managers had fed back to them.

### Leadership of service

- The trust's management structure changed in 2016, five clinical divisions were reduced to three. These included Division of Surgery, Cardiovascular and Cancer, Medicine and Integrated Care, Women children and support services
- The Division of Medicine and Integrated Care was led by a triumvirate management structure of Divisional Director, Director of Operations Director and Director of nursing. The division was further divided into eight directorates across the trust's three main hospital sites. A similar triumvirate leadership structure of clinical director, general manager and lead nurse.
- Renal and specialist medicine was provided at Hammersmith Hospital; Stroke & Neurosciences, Acute & Specialist Medicine, Urgent Care, and Emergency Medicine was provided at Charing Cross Hospital; Acute & Specialist Medicine, Urgent Care, Emergency Medicine, HIV, Sexual Health & Infection was provided at St Mary's Hospital. Integrated Care was provided across all hospital sites. Some medical specialties were included in Division of Surgery, Cardiovascular and Cancer. This included: Cardiac and Clinical Haematology at Hammersmith Hospital Oncology & Palliative Care at Charing Cross Hospital. Cardiac services and haematology were managed as part of the surgery, cancer and cardiovascular services division. The oncology day unit was part of the same division.
- The trust's specialist medicine provision was located at all three sites including Hammersmith Hospital. The specialist medicine services included renal, endocrinology, gastroenterology and infectious diseases. Divisional directors provided trust wide leadership for these three divisions across all the sites in the trust.
- We spoke with nurse managers about the new structure and asked how services at the Hammersmith Hospital site were co-ordinated and managed. They told us there was a site manager who was responsible for the operational co-ordination of services on the hospital site and between sites. Site managers were responsible, for example for bed management on the Hammersmith site. Site managers were involved in divisional meetings to ensure services were developed across all the trust's sites.

# Medical care (including older people's care)

- We asked the specialist medicine leadership team about the configuration of services, which had been brought together under their leadership. They told us they were working together to ensure the safe and effective co-ordination of services and to create a development plan for concentrating specialist medicine services on the Hammersmith site.
  - We saw a head of specialty meeting was held on 14 September 2016 where development plans for the services were discussed together with the development of the new directorate structure.
  - The Chief Executive had held road shows at the Hammersmith site for senior staff. Several managers we spoke with told us they had attended and found the meetings helpful.
  - Ward staff told us their immediate managers were visible and visited the wards every day to discuss operational issues on the ward. They said that executive directors did not often visit. They said they would value their involvement at a time of change.
  - The trust had adopted a project management approach to the changes implemented in 2016. The structure was used to engage key staff in the process, planning and managing work streams such as staff re-deployment and engage with external stakeholders.
- Vision and strategy for this service**
- A trust wide strategy was developed in November 2016 covering five years up to 2021. The trust's vision was to be a world leader in transforming health through innovation in patient care, education and research. The organisational strategy drew clinical, quality and safety, patient and public involvement strategies together into one document. The trust anticipated pressure on NHS funding, the need for increased productivity and efficiency, the move towards patient centred medicine and significant changes in technology, which would enhance healthcare. In response, the trust wanted to develop high quality, sustainable models of care, use the trust's facilities and estate effectively and provide integrated care in partnership with other providers.
  - The trust had developed values they planned to abide by whilst pursuing their strategic goals. These included being compassionate and kind in how staff behaved, aspiring to be the best, seeking new ways to improve the care provided, pushing the boundaries of scientific knowledge, developing expertise and working with the local community. Staff we spoke with knew and understood the trusts vision and values.
- The strategy set out the vision for the future of Hammersmith Hospital to operate as the specialist hospital for North West London, including specialist medicine and surgical hubs and specialist centres for cardiac and cancer services acting as both a local, regional and national provider. The trust had begun to make a number of changes at Hammersmith Hospital towards achieving this objective.
  - The closure of the Medical Assessment Unit at Hammersmith Hospital in August 2016 meant the trust had to develop appropriate services for treating acute medical patients without an on site accident and emergency department or medical assessment unit. The trust developed new services and pathways, for example the haematology and renal triage service and the heart attack centre.
  - Clinical leaders and managers told us there had been no serious incidents because of the changes but recognised there was a risk to acutely ill patients with no access to medical services when needed in an emergency. A number of issues had been dealt with, such as new pathways and inter-site working to ensure patients could be transferred quickly when required. Further work was needed for the future development of specialty medicine, which was now concentrated on the Hammersmith site. The directorate had plans for further development of the planned investigation unit and to review where beds and wards were located across the site although there were no timescales identified for the potential development. Managers told us a number of major challenges had been successfully addressed in 2016, such as new pathways and inter-site working to ensure patients could be transferred quickly when required.
  - Staff we spoke with were aware of the overall strategic direction for the trust and Hammersmith Hospital. They told us they did not know the details, but the chief executive had held meetings on site for senior staff where they received a briefing on the change programme. They said senior managers had cascaded the information to staff throughout the hospital. They described how the loss of acute medicine from the site

# Medical care (including older people's care)

had caused concern but they felt the change programme had been well managed. Staff told us those who were affected by change had time to consider their future roles and some new staff had opted to move from other sites to Hammersmith Hospital, which they thought was positive.

- We were aware of a number of changes that had also taken place regarding the care of older people within the trust. We asked staff about the trust's strategy for care of the elderly. They told us the specialist medical directorate were not responsible for care of elderly. Care of the elderly beds were located across sites and staff told us there was virtual management of care of the elderly. There were dedicated beds on John Humphrey and C8 wards where medical staff specialised in care of the elderly treated these patients. They also contributed to the management of older patients receiving acute medical care on other wards. Following the inspection we saw a strategy for older people's services written in February 2017, which described a number of changes being implemented, which would be evaluated to assess their effectiveness. These included care of the elderly specialists providing specialised liaison for specialist services such as haematology and renal.
- The trust's Executive Transformation Committee was overseeing the development of a programme of clinical strategies and workforce transformation plans to improve the clinical and operational sustainability of services.

## Culture within the service

- Staff we spoke with told us their main concerns were staffing levels and the trust's ability to recruit, although they acknowledged this was a national problem.
- The results of the staff survey showed staff at Hammersmith Hospital felt involved and engaged in the management and organisation of patient services.
- Staff told us they felt respected and valued and that the culture encouraged candour, openness and honesty.
- Staff spoke positively about development opportunities within the trust and the mentorship programme.

- Staff told us there were good working relationships within teams, across the Hammersmith site and between sites in the trust. Managers said there were opportunities to work together on projects with colleagues from the other sites.
- Medical staff in renal services told us about a mediation process, which was undertaken in 2016 in an effort to resolve differences between medical staff. They reported that the work had been partially successful but the problem had not been fully resolved. They described how management was supportive in resolving issues.
- Managers told us about training they had received for developing their teams. The programme was called 'Great Conversations – Supporting performance and development of our people'.

## Governance, risk management and quality measurement

- Governance arrangements were robust and had been revised to take account of recent changes in the management structure. A risk management policy set out the trust's approach to risk management, which described how risk was managed at each level within the organisation.
- The trust had a good structure of medicine governance and safety meetings which included a drug and therapeutics committee, new drugs panel, medicine incident analysis, antibiotic review group, chemotherapy and intrathecal medicine group, non-medical prescribing and patient group direction group and a pharmacy quality and safety group.
- The divisional management team for medicine and integrated care were responsible for providing leadership and managing the division's performance. There was a divisional annual business plan, which was used to develop and deliver service during the year.
- A divisional quality and safety committee oversaw the quality of care provided. This committee reported into the trust executive committee through the divisional directors. The minutes of monthly meetings showed medical, nursing and general managers from each site attended together with representatives from all the



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clinical specialties in the division. The committee discussed safety and effectiveness including incidents, complaints, and infection control. The committee also reviewed service specific risk registers.

- Medical specialities met monthly to discuss quality and safety and reported to the divisional and safety committee. We saw the results of local and national audits and clinical guidelines were discussed by these specialty groups.
- The specialist medicine and cardiac directorates had developed performance scorecards for services located on the Hammersmith site. This included monthly information about the number of incidents, compliance with the trust's policy on venous thrombosis embolism (VTE) monitoring on admission, the number of shifts filled by staff, infection rates, for example *Clostridium difficile*. The scorecard compared performance with previous months for all measures to show if the position deteriorated or improved. Some of the data streams were still under development.
- The medicine and integrated care division was supported by a clinical governance team. The governance lead ensured managers in medical specialties were provided with information on risk and performance.
- A quality improvement team provided training on quality and safety improvement. The quality improvement team had identified priorities, which included for example hand hygiene.
- The medicine and integrated service division risk register showed there were 36 divisional risks. The risk register was reviewed monthly. Individual medical specialties also regularly reviewed directorate risk registers. For example, we saw the haematology risk register had identified a risk, which had emerged following the re-organisation of medical services on the Hammersmith Hospital site. Due to the withdrawal of acute medicine services on the Hammersmith site, the pathway to access level two beds for haematology patients was less clear for a small proportion of patients. Negotiation with cardiac and renal services at senior clinician level was required to ensure patients received the correct level of care. This had also been highlighted by the site operations team, but the issue had not been fully resolved.

## Public and Staff engagement

- The trust had developed a patient and public involvement (PPI) strategy in 2016. The aim of the strategy was to develop public involvement in key decisions about the future of services. The strategy enabled the creation of a forum with 12 community representatives.
- We saw the trust had consulted the public and local stakeholders on the changes to medical services in July 2016 before the changes were implemented.
- The public could become involved by responding to requests for public engagement on the trust website. The website had a regularly updated calendar of all available open events and PPI opportunities.
- Between July and September 2016, there were 3,244 responses to the trust's first "Our Voice" annual staff survey. The survey was carried out over six weeks from 21 July to 2 September 2016. Response rates ranged from 75% to 84% across divisions with a mean of 78%. The response rate in medicine was 78%. The response rate for Hammersmith Hospital was also 78%.
- The results of the survey highlighted issues such staff shortages, enough staff to work with, hiring more staff, a more experienced skill mix, reducing the movement of staff to cover different areas, less agency, more annual leave and sickness cover and improved recruitment as key themes.
- Managers told us they were committed to developing the staff survey and communicating how they intended to respond to the issues highlighted by the survey, ensuring staff saw change as a result. The results of the staff survey provided managers with an opportunity to engage with staff opinions and ideas.
- There was a medicine and integrated care weekly message bulletin, which provided staff with information about incidents, staff who had received awards and other information relevant to the directorate. For example, we saw a number of junior doctors had put themselves forward to join the junior doctors' representative team.
- Managers were developing action plans to address the issues identified in the survey. These included developing greater understanding, guidance and encouragement from leaders and managers and more

# Medical care (including older people's care)

visible leadership 'on the floor' to help during busy times. Managers planned to provide clearer direction, more transparency around decisions, consistent application of policies, which ensured all staff adhered to the same rules, more consistent appraisals and feedback.

- Some staff told us about 'In Our Shoes' workshops, where staff shared with each other what made a good day and what made a bad day at work and what teams, individuals and the trust could do to help each other to have more good days.
- The trust ran a 'make a difference award' for staff. Any staff could be nominated for an award by staff, patients and relatives to receive a certificate. We saw reference to staff who had won the award in the medicine and integrated care staff bulletins.

## **Innovation, improvement and sustainability**

- The trust were using 'experience lab' which was a one year quality improvement (QI) programme for multi-disciplinary teams working in outpatients in all divisions across the trust, using patient feedback to generate and test tailored solutions to improve services.
- Staff we spoke with told us there was an emphasis on innovation and improvement and a wide range of initiatives focusing on improving the quality of care patients' received.
- The specialist medicine leadership team were working on a plan for the future development of services which were to be concentrated on the Hammersmith site.
- The cardiac team had developed plans for training nurses to provide specialised care in the heart attack assessment centre.
- The haematology service had developed VORTEX ports an implantable venous access device made of titanium, to provide long-term access for red cell exchange transfusion, intravenous therapies and blood tests. The device was designed to improve the care provided to patients with sickle cell anaemia.

# Outstanding practice and areas for improvement

## Areas for improvement

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

The trust must ensure all wards and departments follow the trust's medicine management policies so that medicines are safe for administration to patients. In particular for date checking medicines and storing medicines in refrigerators.

The trust must improve the proportion of medical staff completing mandatory training, level 2 adult safeguarding training in particular.

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

The trust should ensure patients and carers have the same access to the trust's PALs service as patients on other sites.

The trust should ensure the cardiac catheter lab complies with the World Health Organisation (WHO) safer surgery checklist.

The trust should review patient transport to ensure day case patients do not wait too long for transport home.

The trust should develop plans for addressing problems with the preparation of oncology treatments at the Hammersmith site and ensure staff and patients are informed. The trusts should also monitor the number of treatments adversely affected by delays in providing oncology medicines.

The trust should clarify and implement a pathway for access to Level 2 beds for Haematology patients

The trust should support clinicians and managers to develop the planned investigation unit and to review how specialty medicine beds and wards were configured across the site.

The trust should improve signage and the environment on the wards by addressing the backlog maintenance programme.

The trust should improve the provision of cardiac rehabilitation services.

The trust should ensure patients with diabetes are able to access foot care.

The trust should ensure all staff particularly those caring for older people fully understand and follow the requirements of the Mental Capacity Act (2005).

The trust should ensure adequate overnight SHO rota cover for clinical haematology.

The trust should review the recording of patients' own controlled drugs to make sure stock levels and administration can be clearly documented.

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

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

(1) Care and treatment must be provided in a safe way for service users.

(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include:

(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.

Staff compliance with trust mandatory training and safeguarding training was low and below trust target of 95%.

#### Regulated activity

#### Regulation

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

(1) Care and treatment must be provided in a safe way for service users.

(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include:

(g) the proper and safe management of medicines;

Staff did not always follow the trust's medicine management policies.