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A

External Services Select Committee

Councillors on the Committee

Councillor John Riley (Chairman)
Councillor Nick Denys (Vice-Chairman)
Councillor Simon Arnold
Councillor Teji Barnes
Councillor Kuldeep Lakhmana
Councillor Ali Milani
Councillor June Nelson
Councillor Devi Radia

Date: **WEDNESDAY, 10 OCTOBER 2018**

Time: **6.00 PM**

Venue: **COMMITTEE ROOM 5 - CIVIC CENTRE, HIGH STREET, UXBRIDGE**

Meeting Details: Members of the Public and Press are welcome to attend this meeting

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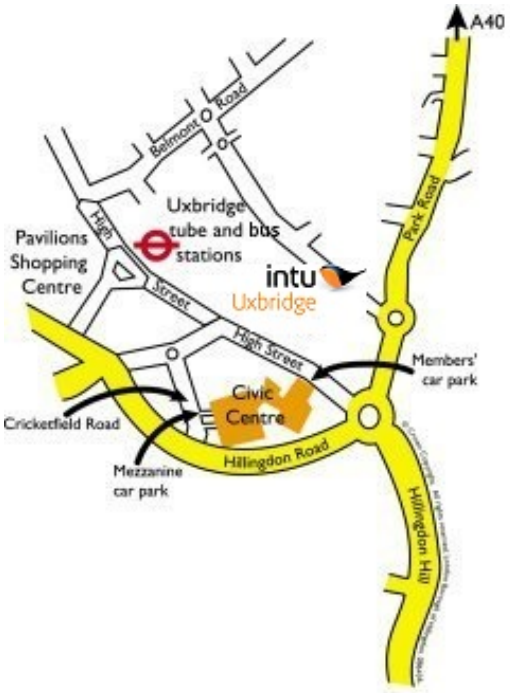

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Terms of Reference

1. To undertake the powers of health scrutiny conferred by the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

2. To work closely with the Health & Wellbeing Board & Local HealthWatch in respect of reviewing and scrutinising local health priorities and inequalities.

3. To respond to any relevant NHS consultations.

4. To scrutinise and review the work of local public bodies and utility companies whose actions affect residents of the Borough.

5. To identify areas of concern to the community within their remit and instigate an appropriate review process.

6. To act as a Crime and Disorder Committee as defined in the Crime and Disorder (Overview and Scrutiny) Regulations 2009 and carry out the bi-annual scrutiny of decisions made, or other action taken, in connection with the discharge by the responsible authorities of their crime and disorder functions.

Agenda

Chairman's Announcements

PART I - MEMBERS, PUBLIC AND PRESS

1 Apologies for absence and to report the presence of any substitute Members

2 Declarations of Interest in matters coming before this meeting

3 Exclusion of Press and Public

To confirm that all items marked Part I will be considered in public and that any items marked Part II will be considered in private

4	Minutes of the previous meeting - 6 September 2018	1 - 8
5	The Hillingdon Hospitals NHS Foundation Trust CQC Inspection Report	9 - 88
6	Work Programme	89 - 104

PART II - PRIVATE, MEMBERS ONLY

7 Any Business transferred from Part I

Minutes

EXTERNAL SERVICES SELECT COMMITTEE

6 September 2018

Meeting held at Committee Room 6 - Civic Centre, High Street, Uxbridge

	Committee Members Present: Councillors John Riley (Chairman), Nick Denys (Vice-Chairman), Simon Arnold, Teji Barnes, Ali Milani, June Nelson, Devi Radia and Jan Sweeting (In place of Kuldeep Lakhmana) **Also Present**: Superintendent Ricky Kandohla, West Area BCU, Metropolitan Police Service Dan Kennedy, Deputy Director, Housing, Environment, Education, Health & Wellbeing **LBH Officers Present**: Nikki O'Halloran (Democratic Services Manager) **Press and Public: 2**
14.	**APOLOGIES FOR ABSENCE AND TO REPORT THE PRESENCE OF ANY SUBSTITUTE MEMBERS** *(Agenda Item 1)* Apologies for absence were received from Councillor Lakhmana (Councillor Sweeting attended in her place).
15.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 3)* **RESOLVED: That all items of business be considered in public.**
16.	**MINUTES OF THE PREVIOUS MEETING - 10 JULY 2018** *(Agenda Item 4)* Councillor Riley thanked Councillor Denys for chairing the meeting on 10 July 2018. It was thought that there was no doubt that residents would want a hospice provision within the north of the Borough and, whilst a new provision at Brunel would be good, this would not address the immediate need. Concern was expressed that patients had been moved from the hospice onto cancer wards in Mount Vernon Hospital following the closure of MSH. Members requested that a single meeting be set up to review progress being made following the closure of Michael Sobell House (MSH) and to establish why the closure took place so quickly and with limited warning. Members were advised that East and North Herts had been contacted on three occasions since the last meeting with a request for information but no response had yet been received. A structural survey of the existing MSH building to identify the extent and cost of remedial work was due in the week commencing 3 September 2018. The cost of the work would determine the scope of funding options and the feasibility of repairs to the existing MSH building. It was noted that the intention was to maintain the provision of hospice beds in the north of the Borough and that, by the end of the month, it would be clearer how this could be achieved. Although an update on the situation would be included on the agenda for the Health and Wellbeing Board meeting on 25

	September 2018, Members were advised that it was the Hillingdon Clinical Commissioning Group's (HCCG's) intention to undertaken consultation with partners and residents on the longer-term service model. The Democratic Services Manager would ask The Hillingdon Hospitals NHS Foundation Trust (THH) to provide a copy of the human resources strategy regarding the expansion of A&E at Hillingdon Hospital before the next Committee meeting. HCCG would be asked to provide an update in relation to the provision of GP services from the Nestles development at its meeting on 13 November 2018. **RESOLVED: That:** **1. following the closure of Michael Sobell House, an additional meeting be scheduled to review action taken to ensure provision of hospice beds in the north of the Borough;** **2. the human resources strategy be forwarded to Committee Members before the next meeting on 10 October 2018;** **3. HCCG be asked to provide an update in relation to the provision of GP services from the Nestles development at its meeting on 13 November 2018; and** **4. the minutes of the meeting on 10 July 2018 be agreed as a correct record.**
17.	**SAFER HILLINGDON PARTNERSHIP PERFORMANCE MONITORING** *(Agenda Item 5)* Mr Dan Kennedy, the Council's Deputy Director, Housing, Environment, Education, Health and Wellbeing, advised that the Community Safety Partnership (known locally as the Safer Hillingdon Partnership (SHP)) was a statutory body with the partners prescribed in legislation. SHP meetings were chaired jointly by the Council's Chief Executive and the Metropolitan Police Service's (MPS's) West Area Basic Command Unit (BCU) Commander. Other partners included representatives from the Probation Service, London Fire Brigade, Public Health and the Community Rehabilitation Company (who had attended the last SHP meeting) as well as the relevant Cabinet Member and the Chairman of Hillingdon's Domestic Abuse Steering Executive. The SHP's role was to provide oversight, champion and steer community safety and reduce the fear of crime using clear communication and the appropriate use of resources. The SHP reviewed its priorities and set targets annually. Mr Kennedy stated that there had been real progress to reduce burglaries in the Borough which were deemed to be a high impact crime in that it impinged on residents' personal space. This reduction had been supported by the provision of Council-funded police officers and through the MetTrace project where covert operations were undertaken by proactive neighbourhood teams and cocooning which was a reactive strategy to protect against the reoccurrence of residential burglary. Burglary would remain a priority for 2018/2019. The longer winter nights could mean an increase in the number of burglaries, so prevention was equally important. As such, Autumn Nights would see police patrols being placed in key areas around the Borough. Challenges had been faced in the Borough in relation to violent crime and knife crime in particular as these offences were often linked to drugs and alcohol. It was noted that the target for "Reduce violence with injury by 5% per annum for the next three years" had not only been missed in 2017/2018 but had also been higher than the baseline for 2016/2017. Members were assured that the use of corrosive liquids had not been a significant issue in the Borough and that processes were in place to respond accordingly.

Superintendent Ricky Kandohla advised that, although there had been no incidents in the last 3-4 weeks, there had been an increase in knife crime in the Borough, particularly round West Drayton and Hayes. Whilst Hillingdon compared well with other boroughs, any small increase in the number of incidents resulted in a disproportionately large percentage increase. Operation Honeybadger had been put in place by the BCU to tackle knife crime and it was likely that this issue would remain a priority for at least 3-5 years. MOPAC had asked that the local authority and BCU provide an action plan to tackle knife crime and youth violence. The key themes of this action plan were:

- Diversion - at school as well as outside of the school gates. As well as school officers, Youth Engagement Officers now played a big role in diversionary activities with young people;
- Prevention - it was anticipated that police visibility would act as a deterrent in some instances. Leaflets had also been handed out and the 'Your Life, You Choose' programme had been running in schools in Ealing and Hillingdon. Stop and search powers were also now being used more widely and had produced results. The powers were useful if used legitimately, proportionately and ethically. To support this, officers were issued with body worn video (BWV) and footage could be reviewed by Stop and Search Monitoring Groups. Section 60 powers were also used to stop and search in an area;
- Communication - it was recognised that the MPS was not always great at communication, but effort was being made to improve this. The BCU had been using different ways to talk to the right people as well as listening to what they had to say, hearing what they said and then taking action. Further work was being undertaken to capitalise on the use of social media to get messages across; and
- Enforcement - activity had included the use of automatic number plate recognition (ANPR) technology to catch perpetrators across area borders.

It was noted that there had not been a reported spike in the level of hate crimes reported. The MPS encouraged instances of hate crime to be reported (*Tell MAMA*) and Hate Crime Liaison Officers were in place at the BCU to speak to communities.

There had been a concerted effort between the local authority and the MPS to reduce anti social behaviour (including littering, dog fouling and noise nuisance) which had resulted in the SHP achieving its targets. Officers had been grant funded by the Council as anti social behaviour (ASB) was seen as a local priority. Resources to deal with ASB included AirSpace (which supported the case management of anti-social behaviour), MARAC (Multi Agency Risk Assessment Conference), PSPOs (Public Spaces Protection Orders) and Section 35 dispersal orders. Consideration needed to be given to any displacement that would be caused as a result of action taken to address ASB in a particular area.

Grant funded resources had also been used in the last year towards the target to reduce the vulnerability score of 75% of those referred to CR MARAC - in 2017/2018 100% had been achieved. MARAC had also increased the number of cases per 10,000 population from 18 in 2016/2017 to 30 in 2017/2018 which is well on the way to achieving the target of 40 cases over three years.

Public confidence in the local police had increased to 64% in 2017/2018 against a 60% target. It was thought that this might be as a result of an increase in police visibility around the Borough. From Supt. Kandohla's perspective, there were challenges involved in working with three SHPs and with three sets of communities and to physically get around 65 wards across the three boroughs in the BCU (Ealing,

Hounslow and Hillingdon). However, to ensure his visibility, he met with the Neighbourhoods teams as often as he could. To give local context, Supt. Kandohla would provide a breakdown of the confidence figures by ward.

Although domestic abuse (DA) had been a priority over the last year, there had been an increase in the number of repeat victims of DA with 1,515 instances in 2017/2018 against a target of 1,253. MOPAC grant funding had helped to develop the DA strategy which had been agreed by Cabinet and Council in June / July 2018. Work had been undertaken to strengthen the DA referral pathways and to refresh the engagement strategy to embed changes such as the risk assessment process. Extensive training had also been undertaken with partner organisations. It was noted that the courts and sentencing also took DA very seriously.

Safeguarding vulnerable people was seen as a priority in Hillingdon. Prior to the BCU, sufficient resources had not been available. However, trained investigators were now in place to manage DA and provide a safe environment for DA victims to report and the safeguarding lead officer regularly attended meetings such as MARAC. It was noted that Hillingdon had achieved the most DA charges in London.

Supt. Kandohla advised that the new Basic Command Unit (BCU) structure had five strands which each had a Superintendent and a Chief Inspector: HQ, Response, Neighbourhoods, Investigation and Safeguarding. There were seven Sergeants in Hillingdon that each managed the Safer Neighbourhoods Teams for 2-3 wards. Each Sergeant had their own skill set, met with Ward Panels and managed their own administration. The five strands were not yet fully staffed. However, Supt. Kandohla advised that new officers were coming into the Borough, a recruitment drive was underway for PCSOs and police graduates were joining the Neighbourhoods teams. He would provide a staffing report at the next crime and disorder meeting on 12 February 2019.

Although the new structure was still bedding in, the BCU had provided the ability to flex resources across three boroughs which had resulted in a better response to 999 calls with officers arriving after 84% of calls. The Response Team had also grown in number and vehicles were now more available that they had been before.

Whilst it was recognised that the former borough-based BCU was an anomaly and a larger command was more effective, concern was expressed in relation to the flexing of resources. Information about response times did not appear to be on the MPS website so there was no way to know whether the introduction of the new BCU had resulted in an increase or decrease in these times. Furthermore, it was queried whether the flexing mechanisms resulted in the performance of the BCU as a whole being scrutinised rather than that of the individual boroughs. Supt. Kandohla advised that Hillingdon and the BCU as a whole were doing well with regard to response times and that he would provide the Committee with this more detailed information. Whilst the ability to flex resources sat with the control room, wards were usually working at above minimum strength and each borough had its own proactive team which worked to prevent increases in crime.

It was noted that a lot of things had not changed since the introduction of the BCU. For example, although a number of buildings were no longer being used, many of the ward officers had remained patrolling the same area and had provided continuity. A Response Team was still working out of Ruislip where there was also a dedicated policing team. Although the geographic area may have changed, the policing concept remained the same.

Members were advised that MOPAC required a minimum commitment in each ward of two police officers and one PCSO. The flexibility now available meant that resources could be drafted in from elsewhere if this minimum strength was likely to be breached or bolster resources to help deal with an incident if needed. The only times that minimum strength would not necessarily be adhered to was during Notting Hill Carnival, New Year's Eve and the Million Mask March. There would also be operational decisions to move officers around the BCU area in relation to gang retribution where there was a danger to life and to prevent harm.

Supt. Kandohla advised that, although there was not a gang culture in Hillingdon, there had been some issues in Northolt and Rayners Lane with possible local affiliations. However, there was no evidence to suggest that there were gangs operating in Hillingdon.

Concern was expressed that residents did not understand the process regarding reporting incidents or the response that they should expect and there had been incidents where calls from residents had not been answered or had been cut off. Although residents were being told that they needed to report crimes, if they were unable to get through on the telephone to report a crime, it did not instil much confidence that the service was improving and would not reflect the true level of service demand. Supt. Kandohla confirmed that it was not acceptable for calls to 101 to go unanswered or for calls to be cut off. He advised that the pan-London service was outsourced and that the contractor had experienced some challenges with recruitment which had now been addressed.

It was noted that the call operator was not based in the Borough and made the decision as to whether or not to send police officers to a reported incident. Whilst it was acknowledged that victims of a burglary wanted to see the police, this was not always possible or practical depending on the information given to the operator. However, the local police operations room did review the calls taken by the operators and could decide to take action. Residents were also able to contact ward based officers on their mobiles. Members agreed that they needed to collate more detail about the issues being raised by residents about specific incidents and pass this on to the police. Furthermore, as some residents would be unaware of the new BCU arrangement, Supt. Kandohla suggested that local Neighbourhoods teams attend community meetings to provide residents with further information.

Members were advised that most police officers now had tablets and residents were able to report crimes online.

West Area BCU had been the third BCU to go live in London. Lessons had been learnt from the introduction of the first two BCUs which had helped the transition in the West Area. It was noted that 999 call performance had improved and there were more officers available than there had been before.

It was noted that, with regard to Section 136 of the Mental Health Act, a Borough Mental Health Liaison Officer had been appointed. S136 gave the police the power to remove a person from a public place (when they appeared to be suffering from a mental disorder) to a place of safety. It was confirmed that the MPS in Hillingdon did not put these individuals in cells as police stations were deemed to be a last resort as a place of safety.

It was suggested that the targets set for 2018/2019 were not challenging enough and that it was disappointing that targets that had not been met in 2017/2018 that had still been rolled forward without any further thought. A 40% increase in knife crime could

	not be seen as a success. Mr Kennedy advised that a lot of work had been undertaken by the police in relation to the knife crime target which had been based on the trends. However, concern was expressed by Members that this rationale was weakened by the fact that the target remained the same as the previous year yet the BCU now had the ability to flex its resources. It was argued that, if resources could be flexed to reduce instances of burglary in the Borough, why could this not also be done for knife crime. Although some Q1 results for 2018/2019 seemed high, it was noted that there were some seasonal variances. Mr Kennedy advised that this was something that would be monitored at the SHP meetings. It was agreed that, as a large amount of statistical information was routinely provided at a ward level for Safer Neighbourhood Boards, rather than duplicate effort, Supt. Kandohla agreed to forward this information to the Democratic Services Manager for circulation to the Committee. This information would then be included on the agenda as a standard for future crime and disorder related External Services Select Committee meetings. Supt. Kandohla advised that he was unaware of the detail of the proposed closure of the interview suite managed by the Child Abuse and Sexual Offences (CASO) unit in Northwood. Once he had more information, he would pass this on to the Democratic Services Manager for circulation to the Committee. **RESOLVED: That:** **1. the West Area BCU provide a full staffing report at the meeting on 12 February 2019;** **2. the ward level statistical information provided to Safer Neighbourhood Boards be forwarded to the Democratic Services Manager for circulation to the Committee;** **3. ward level statistical information provided to Safer Neighbourhood Boards be included on the agenda for future crime and disorder related External Services Select Committee meetings;** **4. Supt. Kandohla provide more information regarding the proposed closure of the interview suite managed by the Child Abuse and Sexual Offences (CASO) unit in Northwood; and** **5. the report be noted.**
18.	**UPDATE ON THE IMPLEMENTATION OF RECOMMENDATIONS FROM PAST REVIEWS OF THE COMMITTEE** *(Agenda Item 6)* The Chairman explained the context of each of the reviews that had been undertaken. **RESOLVED: That the report be noted.**
19.	**WORK PROGRAMME 2017/2018** *(Agenda Item 7)* It was noted that, since the Committee's last meeting on 10 July 2018, information had come to light which had shown that measures had been put in place resulting in significant improvements in the Borough's cancer screening and diagnostics performance. As such, it was agreed that, rather than hold a full scrutiny review of the issue, it be considered as a single meeting review on 15 January 2019. Members were advised that a Working Group had previously been set up to look at GP pressures but that the final report had not been considered by Cabinet. Pressures on GPs continued with an increasing workload which had impacted on appointment

	waiting times in some areas and the requirement for GP extended hours. Other issues included deprivation and GP recruitment. It was recognised that the issues faced by GPs were complex and exacerbated by the number of appointment non-attendances. It was agreed that Ms Caroline Morison, Chief Operating Officer at Hillingdon Clinical Commissioning Group, be asked to provide information about the number of GP appointments in Hillingdon where patients did not attend (DNA). It was noted that, with regard to new building developments, it was important that the infrastructure was in place beforehand to ensure that there was adequate provision of services such as GP practices, schools, etc, before the development went ahead. Whilst the provision of a surgery within a new development would be ideal, there were not enough GPs to be able to staff new practices or manage the current level of demand. Successive London Mayors had championed the need for additional housing but had not properly considered the provision of supportive infrastructure. Whilst CIL payments could be seen to address this infrastructure issue, this did not work in practice. It was agreed that a Select Panel be set up to revisit the GP pressures review. It was suggested that transport provision within the Borough be considered as a future review topic. This topic could look at Transport for London (TfL), Crossrail, bus route changes and Dial-a-Ride. **RESOLVED: That:** **1. a single meeting review of cancer screening and diagnostics be held on 15 January 2019.** **2. Ms Caroline Morison be asked to provide information about the number of GP appointments in Hillingdon where patients did not attend (DNA);** **3. a Select Panel be set up to revisit the GP pressures review;** **4. transport provision within the Borough be considered as a future review topic; and** **5. the report be noted.**
	The meeting, which commenced at 6.00 pm, closed at 8.20 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki O'Halloran on 01895 250472. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.

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EXTERNAL SERVICES SELECT COMMITTEE – THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST CQC INSPECTION REPORT

Committee name	External Services Select Committee
Officer reporting	Nikki O'Halloran, Chief Executive's Office
Papers with report	Appendix A – CQC Inspection Report
Ward	n/a

HEADLINES

To enable the Committee to question representatives of The Hillingdon Hospitals NHS Foundation Trust (THH) in relation to the report published on 24 July 2018 by the Care Quality Commission (CQC) with the findings of its inspection and the resultant action plan.

RECOMMENDATIONS:

That the External Services Select Committee makes comment on the information provided and notes the presentations.

SUPPORTING INFORMATION

Care Quality Commission (CQC)

The CQC is the independent regulator of health and adult social care in England. It makes sure that health and social care services provide people with safe, effective, compassionate, high-quality care and encourages care services to improve. The CQC undertakes inspections to find evidence to help its inspectors answer five key questions: is the service safe, effective, caring, responsive and well-led? Within these domains, CQC inspectors are looking at a range of practices:

- Is it safe?
    - Safeguarding and protection from abuse
    - Managing risks
    - Safe care and treatment
    - Medicines management
    - Track record
    - Learning when things go wrong
- Is it effective?
    - Assessing needs and delivering evidence-based treatment
    - Monitoring outcomes and comparing with similar services
    - Staff skills and knowledge
    - How staff, teams and services work together
    - Supporting people to live healthier lives
    - Consent to care and treatment
- Is it caring?

    - Kindness, respect and compassion
    - Involving people in decisions about their care
    - Privacy and dignity
- Is it responsive?
    - Person-centred care
    - Taking account of the needs of different people
    - Timely access to care and treatment
    - Concerns and complaints
- Is it well-led?
    - Leadership capacity and capability
    - Vision and strategy
    - Culture of the organisation
    - Governance and management
    - Management of risk and performance
    - Management of information
    - Engagement and involvement
    - Learning, improvement and innovation

CQC Inspection of Hillingdon Hospital

1. Overall, THH continues to be rated as 'Requires improvement' with an inadequate rating for providing safe care and a 'good' rating for caring. CQC rated THH as 'Requires improvement' for providing effective care, being responsive to patients' needs and being well-led.

2. The following table illustrates the ratings provided for the Trust as a whole and the direction of travel in the relevant domains:

	Safe	Effective	Caring	Responsive	Well-led	Overall
The Hillingdon Hospital	Inadequate ↓ Jul 2018	Inadequate ↓ Jul 2018	Good → ← Jul 2018	Requires improvement → ← Jul 2018	Inadequate ↓ Jul 2018	Inadequate ↓ Jul 2018
Mount Vernon Hospital	Requires improvement Oct 2014	Good Oct 2014	Good Oct 2014	Requires improvement Oct 2014	Requires improvement Oct 2014	Requires improvement Oct 2014
Overall trust	Inadequate ↓ Jul 2018	Requires improvement → ← Jul 2018	Good → ← Jul 2018	Requires improvement → ← Jul 2018	Inadequate ↓ Jul 2018	Inadequate ↓ Jul 2018

3. The CQC carried out an inspection of Hillingdon Hospital in March and April 2018 as part of its comprehensive inspection programme of all NHS acute providers. The following table illustrates the CQC ratings provided for Hillingdon Hospital in its most recent inspection report:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓ Jul 2018	Inadequate Jul 2018	Requires improvement ↓ Jul 2018	Requires improvement ↔ Jul 2018	Inadequate ↓ Jul 2018	Inadequate ↓ Jul 2018
Medical care (including older people's care)	Good ↑ Jul 2018	Good ↑ Jul 2018	Good ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018
Surgery	Inadequate ↓ Jul 2018	Requires improvement ↔ Jul 2018	Good ↔ Jul 2018	Requires improvement ↔ Jul 2018	Inadequate ↓ Jul 2018	Inadequate ↓ Jul 2018
Critical Care	Requires improvement ↔ Jul 2018	Good ↑ Jul 2018	Good ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018
Maternity	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Outstanding Jul 2018	Good Jul 2018
Service for children and young people	Good ↑ Jul 2018	Good ↔ Jul 2018	Good ↔ Jul 2018	Good ↑ Jul 2018	Good ↑ Jul 2018	Good ↑ Jul 2018
End of life care	Good ↑ Jul 2018	Good ↑ Jul 2018	Good ↔ Jul 2018	Good ↑ Jul 2018	Good ↑ Jul 2018	Good ↑ Jul 2018
Outpatients	Requires improvement ↔ Jul 2018		Good Jul 2018	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Overall	Inadequate ↓ Jul 2018	Requires improvement ↔ Jul 2018	Good ↔ Jul 2018	Requires improvement ↔ Jul 2018	Inadequate ↓ Jul 2018	Inadequate ↓ Jul 2018

4. Although Hillingdon Hospital has been rated separately as 'Inadequate', when combined with the rating for Mount Vernon Hospital, the overall Trust rating increases to 'Requires improvement'.

5. The key findings from the CQC inspection were as follows:
   a) There had been some improvement to safe levels of staffing. However some services within the trust did not have enough permanent nursing and medical staff to ensure the provision of safe care and treatment. However, they used bank and agency staff to cover gaps in the staff provision.
   b) We found out of date copies of the major incident plan on some wards and this was against the trust's own policy.

c) The trust had not improved in relation to the testing of portable electrical equipment. We found that not all portable appliances had been tested.
d) We were not assured that high-risk patient groups were screened for MRSA at pre-admission.
e) Staff did not always maintain appropriate records of patients' care and treatment. Records were not always clear, up-to-date and available to all staff providing care.
f) We were not assured that the laser service met the Medicines and Healthcare Products Regulatory Agency safety standards.
g) There was low participation in clinical audits and the trust performed poorly in some.
h) Appraisal rates were low in some areas.
i) Staff did not always understand their roles and responsibilities in relation to the Mental Capacity Act 2005, in particular in relation to Deprivation of Liberty Safeguards (DoLS).
j) The trust did not audit the World Health Organisation (WHO) five steps to safer surgery in 2017.
k) There were no pre-operative fasting audits for patients fasting before surgery.
l) The trust did not always actively monitor the effectiveness of care and treatment and use this information to improve services.
m) Staff cared for patients with compassion. Staff treated patients and their families with dignity, kindness and respect.
n) We observed positive and compassionate interactions between staff and patients.
o) Staff involved patients and those close to them in decisions about their care and treatment. Patients and their relatives were kept informed of ongoing plans and treatment. They told us that they felt involved in the decision making process and were given clear information about their treatment.
p) Relatives were happy with the communication and information given to them from staff.
q) Staff provided emotional support to patients to minimise their distress.
r) The trust did not meet the target to admit, discharge, or transfer and did not meet the standard that patients should wait no more than one hour for initial treatment.
s) The A&E waiting area for patients who attended by their own means was very crowded with insufficient seating.
t) We found that staff had poor awareness of the needs of people with learning disabilities.
u) Translation services were not always offered to patients.
v) The trust provided a range of information leaflets including support groups. However, similarly to the last inspection we did not see any information printed in any other language.
w) Space within the surgery division was not suitable for inpatients due to the lack of essential equipment and washing facilities.
x) The trust's investigation and closure of complaints was not in line with their complaints policy which states complaints should be completed in 30 days.
y) Since the last inspection, there had been limited improvement in the facilities on the ITU for relatives and visitors.
z) There were limited examples of departments supporting patients to manage their own health.
aa) The bereavement service had limited opening hours and inappropriate waiting areas for bereaved family members
bb) There was a large backlog of estates maintenance.
cc) Local risk registers did not always reflect risks described by staff in some areas.
dd) Matrons and managers within the trust did not have the capacity to effectively lead their teams due to pressures faced operationally.

ee) The senior management team had not taken note of all of the concerns raised at the previous inspection.
ff) We found that divisional and executive team were not visible in some areas and rarely visited some departments.
gg) Staff struggled to locate clinical guidelines quickly as the trust intranet search engine was not user friendly.
hh) The department had managers with the right skills to run the service; however senior nurses felt that their managerial duties were at times excessive of their role.
ii) We were not assured that there were adequate governance procedures for the laser service as set by the Medicines and Healthcare Products Regulatory Agency safety standards.

6. The CQC saw examples of outstanding practice in Maternity, Children and young people's services and End of life care, all of which had improved in their ratings at this inspection:
   a) The new midwife team to support women with complex care needs including mental health needs was innovative. There was 24 hour telephone support for vulnerable women, and support for mother and baby could potentially extend for up to a year,
   b) The senior maternity team was outward looking and proactive within the North West London maternity network. They had worked very effectively to manage risks and plan for contingencies to accommodate the agreed increase in the number of births following the closure of another hospital's maternity service, an event that had taken place earlier than anticipated.
   c) The service was an early leader in establishing an effective system of midwife supervision, independent of line management, following the change in the way the Nursing and Midwifery Council (NMC) regulated midwives. Nine Professional Midwifery Advocates provided 24 hour on call cover supporting and developing effective midwifery practice which staff said had proved invaluable to new staff as the service expanded.
   d) The maternity team collected high quality audit data to enable them to monitor and improve the service, and used the data promptly to achieve change where necessary.
   e) The postnatal team had identified a simple but effective solution to the problem of urinary retention when women had a catheter removed. Posters in toilets and postnatal wards gave women a 5 point plan to prompt them drink enough to ensure their bladder was working properly. This was a good example of translating staff ideas into practical action.
   f) Midwives and support workers used a secure digital app group that enabled them to see and opt into vacant shifts. This had significantly improved the fill rate of shifts. They also had a closed staff Facebook page for information on study days which supplemented formal channels of communication through newsletters and team meetings.
   g) In Children and young people's services, the department ran outreach diabetes clinics in local schools which had improved engagement with patients and attendance rates.
   h) In End of life care, the audits that the mortuary staff completed were very thorough and the team worked hard to improve each month.

7. However, there were also areas identified by the CQC where the Trust needs to make improvements:

The Trust MUST:

In urgent and emergency services:

- Monitor the safety of the waiting room including clinical oversight of deteriorating patients.
- Improve infection prevention and control practices.
- Improve storage and checks of medicines.
- Ensure the mental health interview room is fit for purpose.
- Ensure that all electronically recorded incidents are reviewed in a timely manner so that risks are identified and lessons can be learnt.

In surgery:

- Risk assess all areas where spaces not designed for inpatients are being used to house patients overnight.
- Ensure that all staff are aware of sepsis and undertake training in identifying patients with sepsis.
- Comply with the World Health Organisation and undertake WHO five steps to safer surgery auditing.
- Ensure that all areas within the hospital have access to a resuscitation trolley.
- Ensure that senior staff are available to assist staff in planning and patient care.

In critical care

- Ensure effective systems and policies are in place for sepsis management, including sepsis training for staff.

In outpatients

- Ensure the laser service meets all the requirements set forth in the Medicines and Healthcare Products Regulatory
- Agency safety standards.
- Ensure that clinical records are maintained in an orderly, clear and legible manner and that this is checked on a
- regular basis.

The Trust should:

In urgent and emergency services:

- Review the use of the fifth bay in the resuscitation area.
- Ensure paediatric patients are separated from adult patients in the waiting area and consider how paediatric patients are safely monitored during their wait to be seen by a streaming nurse.
- Improve the quality of record keeping.
- Improve the safety in the department by reducing public access.
- Enable access to training for junior doctors.
- Ensure early warning scores are regularly recorded.
- Improve on pain assessments and timely administration of pain relieving medicines.
- Initiate regular comfort rounds.
- Improve appraisal rates.
- Provide adequate translation service for patients.

- Ensure the needs of patients with a learning difficulty are better understood.

In medical care:

- Ensure safe levels of staff to ensure the provision of safe care and treatment.
- Ensure staff keep appropriate records of patients' care and treatment, in particular, dementia assessments, bed rail assessments and capacity assessments.
- Ensure there are up to date copies of the major incident plan on the wards in accordance with the trust policy.
- Ensure portable electrical equipment is tested.
- Have a named individual as the authorised person or competent person for endoscopes in line with the Heath Test
- Memorandum 01-01: Decontamination of reusable medical devices.
- Ensure staff understand their roles and responsibilities in relation to the Mental Capacity Act 2005.
- Ensure senior staff check agency staff competencies.
- Ensure staff follow trust policy on the management of patients with a learning disability.
- Ensure there is consistency in relation to document completion across the wards and ensure sepsis protocol forms/paperwork is standardised.

In surgery:

- Assess and improve the quality of infection prevent control in surgical areas, given the wear and tear of the premises.
- Ensure that maintenance in theatres is booked in on appropriate days and not occur during theatre lists.
- Put in place standard operating procedures for overcrowding at the hospital.
- Ensure that staff are aware of protocols that are in place to ensure that relevant patients have the appropriate screening at preadmission.
- Undertake preoperative fasting audits to ensure compliance with policies.
- Ensure that DoLS are understood and the correct paperwork is completed before a DoLS is put in place for a patient.
- Ensure staff are aware that all patients over 75 should be routinely screened for dementia.
- Comply with the national guidance issued by the associations of anaesthetists of Great Britain and Ireland, in relation to the recovery room facility. This guidance recommends that the ratio of beds to operating theatres should not be less than two.

In critical care

- Ensure that there is improved feedback to staff from incidents and wider learning from incidents across all staff groups.
- Ensure there are formal mobility and mortality meetings and learning is shared with the wider directorate.
- Ensure that the ITU is compliant with HBN04-02 building standards and heating and ventilation for health sector building (HTM 03-01) standards.
- Ensure that staff follow the 'Five Moments for Hand Hygiene' guidance at all time.
- Ensure that there is no dust on equipment and on any high surfaces within the department.

- Ensure that there are reliable systems in place to check the difficult airway/ intubation trolley.
- Ensure that all nursing staff have up-to-date equipment competencies.
- Ensure that there are sufficient nursing staff at each shift.
- Have a practice nurse educator in place with two third of their time dedicated to this role.
- Ensure that oxygen is prescribed on the patient prescription chart as per the trust policy.
- The unit should ensure that there is 24-hour cover provided by the critical care outreach team.
- Consider improving the facilities for patients and relatives, including shower facilities for patients.
- Have systems in place to improve the capacity and flow of the patients and reduce delayed discharges.
- Consider providing ITU follow-up clinics once patients are discharged from the hospital.
- Ensure that there is consistent information available about the visiting hours for relatives.
- Provide training for staff on identifying the needs of patients or relatives with learning disability.
- Ensure that call bells are within easy reach of patients.
- Ensure that there is more cohesive working with ITU and staff do not feel isolated or disjointed from the division.
- Ensure that there is an effective governance structure and system in place for the unit that feeds into the divisional governance structure.
- Ensure that the risk register reflects all their risks.
- Ensure that the intranet search facility is improved and staff can access clinical guidelines quickly.
- Ensure that there is an agreed strategy in place.

In maternity

- Ensure good hand hygiene is fully embedded so all staff clean their hands before and after patient contact.
- Seek to minimise delays in transferring women to the delivery suite to avoid compromising women's privacy and dignity through labouring in the antenatal ward or triage.

In end of life care

- Ensure the service begins a programme of auditing of key safety measures for end of life patients.
- Ensure that patients are receiving mental capacity assessments where necessary and that these are documented in
- patient records.
- Ensure that all staff are trained in the use of syringe pumps where necessary.
- Ensure that the bereavement service is available to patients and there is adequate space to have private conversations.

In outpatients

- Address the large backlog of estates maintenance in a prompt manner and that any repair issues does not hinder the
- daily service operations.
- Address concerns regarding managerial duties for senior nurses in times of staff shortages.
- Take stronger action to ensure that all shifts are filled and that extra bank staff be recruited to fill vacancies if required.
- Deal with divisional and departmental risks in a timely manner.
- Actively engage with staff and patients in order to drive service improvement.

8. The Committee should note that, following an inspection, THH is required to respond to areas of concern that have been identified, develop an action plan to address them and make improvements. The CQC will then follow up on any action it tells the Trust to take which may be by contacting the Trust or visiting the service to carry out a focused inspection. The inspection findings were discussed at a quality summit meeting on 25 September 2018 with the Trust, CQC and partners in the local health and social care system.

WITNESSES

The following representatives from the Trust have been invited to attend the meeting to answer questions from Members:

- Interim Chief Executive
- THH Board Chair
- Medical Director
- Director of Nursing
- Chief Operating Officer

POSSIBLE KEY LINES OF ENQUIRY

Following the CQC's inspection of THH, the Trust put together an action plan for improvement. The Committee is interested in the actions that are contained therein as well as:

- What actions have already been implemented?
- What actions have not yet been implemented (and why)?
- What are the barriers to implementing actions and how will these be overcome? If the intended action cannot be taken, what alternative action will be taken?
- How are the actions being monitored?
- With regard to actions that have been implemented, what impact have they had on finances, staff and patients?

The Hillingdon Hospitals NHS Foundation Trust

Inspection report

Pield Heath Road
Uxbridge
Middlesex
UB8 3NN
Tel: 01895238282
www.thh.nhs.uk

Date of inspection visit: 6 Mar to 27 Apr 2018
Date of publication: 24/07/2018

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

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

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

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

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

The trust has 509 beds including:

- 295 medical care beds;
- 95 surgery beds;
- 60 maternity beds;
- 25 paediatric beds;
- 15 neonate beds;
- 10 gynaecology beds;
- and 9 ITU beds

Overall summary

Our rating of this trust stayed the same . We rated it as Requires improvement 

What this trust does

The trust runs services at The Hillingdon Hospital and Mount Vernon Hospital.

It provides urgent and emergency care, medical care, surgery, critical care, maternity, children's and young people services, end of life care and outpatients services at The Hillingdon Hospital, and minor injury services, surgery, medical care and outpatients services at Mount Vernon Hospital. The trust has 509 beds. We only inspected services at Hillingdon Hospital.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

Summary of findings

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Between 6 and 8 March 2018 we inspected all eight core services provided by this trust at one of its sites – Hillingdon Hospital. We carried out further unannounced visits for a 10-day period following the core service inspection.

- We inspected Urgent and Emergency Care because we rated the service as requires improvement during our last inspection.
- We inspected Medical Care because it had previously been rated as requires improvement during our last inspection.
- We inspected Surgery because we rated it as requires improvement during our last inspection.
- We inspected End of Life Care because we rated the service as requires improvement during our last inspection.
- We inspected Children's and Young People Services because we rated the service as requires improvement during our last inspection.
- We inspected Outpatients because we rated the service as requires improvement during our last inspection.
- We inspected critical care because we rated the service as requires improvement during our last inspection.
- We inspected maternity because we rated the service as requires improvement during our last inspection.

From 24 to 26 April 2018 we conducted a trust wide well led inspection as part of our scheduled inspection programme.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed: Is this organisation well-led?

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

- We rated safe and well-led at Hillingdon Hospital as inadequate; effective and responsive as requires improvement, and caring as good. We rated three of the trust's 12 core services as good, three as requires improvement and two service as inadequate. In rating the trust, we took into account the current ratings of the four services at Mount Vernon Hospital not inspected this time.
- We rated well-led for the trust overall as requires improvement.

Are services safe?

Our rating of safe went down. We rated safe as inadequate.

- There was deterioration in infection prevention and control since the time of the last inspection. We found inconsistencies in hand hygiene practice amongst staff, during ward rounds.
- Medicines were not always appropriately stored or checked in the ED.
- There was poor recognition of sepsis.

Summary of findings

- There had been some improvement to safe levels of staffing. However some services within the trust did not have enough permanent nursing and medical staff to ensure the provision of safe care and treatment. However, they used bank and agency staff to cover gaps in the staff provision.
- We found out of date copies of the major incident plan on some wards and this was against the trust's own policy.
- The trust had not improved in relation to the testing of portable electrical equipment. We found that not all portable appliances had been tested.
- We were not assured that high-risk patient groups were screened for MRSA at pre-admission.
- Staff did not always maintain appropriate records of patients' care and treatment. Records were not always clear, up-to-date and available to all staff providing care.
- We were not assured that the laser service met the Medicines and Healthcare Products Regulatory Agency safety standards.

However:

- Staff were confident about how to record incidents. Staff recognised incidents and near misses and reported them appropriately. Senior staff investigated incidents and shared lessons learnt with staff. There was an open and constructive culture of sharing and learning from incidents.
- There had been an improvement in relation to safety monitoring and the collection and display of safety information on the wards.
- There was consistent and effective use of National Early Warning Scores (NEWS) including appropriate escalation.
- Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk, or had been exposed to abuse. There was a clear and effective process to ensure that potential safeguarding concerns were escalated.

Are services effective?

Our rating of effective stayed the same. We rated effective as requires improvement.

- There was low participation in clinical audits and the trust performed poorly in some.
- Appraisal rates were low in some areas.
- Staff did not always understand their roles and responsibilities in relation to the Mental Capacity Act 2005, in particular in relation to Deprivation of Liberty Safeguards (DoLS).
- The trust did not audit the World Health Organisation (WHO) five steps to safer surgery in 2017.
- There were no pre-operative fasting audits for patients fasting before surgery.
- The trust did not always actively monitor the effectiveness of care and treatment and use this information to improve services.

However:

- There was a multidisciplinary approach to patient care and staff worked well together to deliver an effective service.
- The trust provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- All staff had access to an electronic records system that they could all update.

Summary of findings

- The hospital had a dedicated pain team. There was good documentation for recording pain. Patients we spoke with told us that there was good pain management.

Are services caring?

Our rating of caring stayed the same. We rated caring as good.

- Staff cared for patients with compassion. Staff treated patients and their families with dignity, kindness and respect. We observed positive and compassionate interactions between staff and patients.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients and their relatives were kept informed of ongoing plans and treatment. They told us that they felt involved in the decision-making process and were given clear information about their treatment.
- Relatives were happy with the communication and information given to them from staff.
- Staff provided emotional support to patients to minimise their distress.

Are services responsive?

Our rating of responsive stayed the same. We rated responsive as requires improvement.

- The trust did not meet the target to admit, discharge, or transfer and did not meet the standard that patients should wait no more than one hour for initial treatment.
- The A&E waiting area for patients who attended by their own means was very crowded with insufficient seating.
- We found that staff had poor awareness of the needs of people with learning disabilities.
- Translation services were not always offered to patients.
- The trust provided a range of information leaflets including support groups. However, similarly to the last inspection we did not see any information printed in any other language.
- Space within the surgery division was not suitable for inpatients due to the lack of essential equipment and washing facilities.
- The trust's investigation and closure of complaints was not in line with their complaints policy which states complaints should be completed in 30 days.
- Since the last inspection, there had been limited improvement in the facilities on the ITU for relatives and visitors.
- There were limited examples of departments supporting patients to manage their own health.
- The bereavement service had limited opening hours and inappropriate waiting areas for bereaved family members
- There was a large backlog of estates maintenance.

However:

- The trust planned and provided services in a way that met the needs of local people The trust had a frailty pathway, supported by specialists, to safely reduce admissions and length of stay for elderly patients and ambulatory care pathways.
- The trust delivered a broad range of services including speciality and one-stop clinics.
- There was a mental health matron seconded from a local trust who supported staff to offer a better patient experience to those with mental health issues.
- We observed patient's dietary needs and fluid restrictions clearly displayed above patients beds.

Summary of findings

- The trust treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Are services well-led?

Our rating of well led went down. We rated well led as inadequate.

- Local risk registers did not always reflect risks described by staff in some areas.
- Matrons and managers within the trust did not have the capacity to effectively lead their teams due to pressures faced operationally.
- The senior management team had not taken note of all of the concerns raised at the previous inspection.
- We found that divisional and executive team were not visible in some areas and rarely visited some departments.
- Staff struggled to locate clinical guidelines quickly as the trust intranet search engine was not user friendly.
- The department had managers with the right skills to run the service; however senior nurses felt that their managerial duties were at times excessive of their role.
- We were not assured that there were adequate governance procedures for the laser service as set by the Medicines and Healthcare Products Regulatory Agency safety standards.

However:

- Staff told us they enjoyed good local teamwork.
- The values of the trust were embedded and staff at all levels were able to tell us what the trust values were and how they applied to their roles.
- There was a culture of honesty, openness and transparency.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Quality and safety received sufficient coverage in board meetings, and in other relevant meetings below board level.

Ratings tables

The ratings tables in our full report show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in Maternity, Children and young people's services and End of life care, all of which had improved in their ratings at this inspection.

Areas for improvement

We found areas for improvement in 74 things where the trust should make improvements.

For more information, see the Areas of improvement section of this report.

Summary of findings

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections and engagement meetings with the trust.

Outstanding practice

We found examples of outstanding practice in Maternity, Children and young people's services and End of life care, all of which had improved in their ratings at this inspection.

- The new midwife team to support women with complex care needs including mental health needs was innovative. There was 24 hour telephone support for vulnerable women, and support for mother and baby could potentially extend for up to a year,
- The senior maternity team was outward looking and proactive within the North West London maternity network. They had worked very effectively to manage risks and plan for contingencies to accommodate the agreed increase in the number of births following the closure of another hospital's maternity service, an event that had taken place earlier than anticipated.
- The service was an early leader in establishing an effective system of midwife supervision, independent of line management, following the change in the way the Nursing and Midwifery Council (NMC) regulated midwives. Nine Professional Midwifery Advocates provided 24 hour on call cover supporting and developing effective midwifery practice which staff said had proved invaluable to new staff as the service expanded.
- The maternity team collected high quality audit data to enable them to monitor and improve the service, and used the data promptly to achieve change where necessary.
- The postnatal team had identified a simple but effective solution to the problem of urinary retention when women had a catheter removed, Posters in toilets and postnatal wards gave women a 5 point plan to prompt them drink enough to ensure their bladder was working properly. This was a good example of translating staff ideas into practical action
- Midwives and support workers used a secure digital app group that enabled them to see and opt into vacant shifts. This had significantly improved the fill rate of shifts. They also had a closed staff Facebook page for information on study days which supplemented formal channels of communication through newsletters and team meetings.
- In Children and young people's services, the department ran outreach diabetes clinics in local schools which had improved engagement with patients and attendance rates.
- In End of life care, the audits that the mortuary staff completed were very thorough and the team worked hard to improve each month.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services.

In Urgent and emergency services:

Summary of findings

The trust must:

- Monitor the safety of the waiting room including clinical oversight of deteriorating patients.
- Improve infection prevention and control practices.
- Improve storage and checks of medicines.
- Ensure the mental health interview room is fit for purpose.
- Ensure that all electronically recorded incidents are reviewed in a timely manner so that risks are identified and lessons can be learnt.

The trust should:

- Review the use of the fifth bay in the resuscitation area.
- Ensure paediatric patients are separated from adult patients in the waiting area and consider how paediatric patients are safely monitored during their wait to be seen by a streaming nurse.
- Improve the quality of record keeping.
- Improve the safety in the department by reducing public access.
- Enable access to training for junior doctors.
- Ensure early warning scores are regularly recorded.
- Improve on pain assessments and timely administration of pain relieving medicines.
- Initiate regular comfort rounds.
- Improve appraisal rates.
- Provide adequate translation service for patients.
- Ensure the needs of patients with a learning difficulty are better understood.

In Medical care:

The trust should:

- Ensure safe levels of staff to ensure the provision of safe care and treatment.
- Ensure staff keep appropriate records of patients' care and treatment, in particular, dementia assessments, bed rail assessments and capacity assessments.
- Ensure there are up to date copies of the major incident plan on the wards in accordance with the trust policy.
- Ensure portable electrical equipment is tested.
- Have a named individual as the authorised person or competent person for endoscopes in line with the Heath Test Memorandum 01-01: Decontamination of reusable medical devices.
- Ensure staff understand their roles and responsibilities in relation to the Mental Capacity Act 2005.
- Ensure senior staff check agency staff competencies.
- Ensure staff follow trust policy on the management of patients with a learning disability.
- Ensure there is consistency in relation to document completion across the wards and ensure sepsis protocol forms/ paperwork is standardised.

Summary of findings

In Surgery:

The trust must:

- Risk assess all areas where spaces not designed for inpatients are being used to house patients overnight.
- Ensure that all staff are aware of sepsis and undertake training in identifying patients with sepsis.
- Comply with the World Health Organisation and undertake WHO five steps to safer surgery auditing.
- Ensure that all areas within the hospital have access to a resuscitation trolley.
- Ensure that senior staff are available to assist staff in planning and patient care.

The trust should:

- Assess and improve the quality of infection prevent control in surgical areas, given the wear and tear of the premises.
- Ensure that maintenance in theatres is booked in on appropriate days and not occur during theatre lists.
- Put in place standard operating procedures for overcrowding at the hospital.
- Ensure that staff are aware of protocols that are in place to ensure that relevant patients have the appropriate screening at preadmission.
- Undertake preoperative fasting audits to ensure compliance with policies.
- Ensure that DoLS are understood and the correct paperwork is completed before a DoLS is put in place for a patient.
- Ensure staff are aware that all patients over 75 should be routinely screened for dementia.
- Comply with the national guidance issued by the associations of anaesthetists of Great Britain and Ireland, in relation to the recovery room facility. This guidance recommends that the ratio of beds to operating theatres should not be less than two.

In Critical care:

The trust must:

- Ensure effective systems and policies are in place for sepsis management, including sepsis training for staff.

The trust should:

- Ensure that there is improved feedback to staff from incidents and wider learning from incidents across all staff groups.
- Ensure there are formal mobility and mortality meetings and learning is shared with the wider directorate.
- Ensure that the ITU is compliant with HBN04-02 building standards and heating and ventilation for health sector building (HTM 03-01) standards.
- Ensure that staff follow the 'Five Moments for Hand Hygiene' guidance at all time.
- Ensure that there is no dust on equipment and on any high surfaces within the department.
- Ensure that there are reliable systems in place to check the difficult airway/ intubation trolley.
- Ensure that all nursing staff have up-to-date equipment competencies.
- Ensure that there are sufficient nursing staff at each shift.
- Have a practice nurse educator in place with two third of their time dedicated to this role.

Summary of findings

- Ensure that oxygen is prescribed on the patient prescription chart as per the trust policy.
- The unit should ensure that there is 24-hour cover provided by the critical care outreach team.
- Consider improving the facilities for patients and relatives, including shower facilities for patients.
- Have systems in place to improve the capacity and flow of the patients and reduce delayed discharges.
- Consider providing ITU follow-up clinics once patients are discharged from the hospital.
- Ensure that there is consistent information available about the visiting hours for relatives.
- Provide training for staff on identifying the needs of patients or relatives with learning disability.
- Ensure that call bells are within easy reach of patients.
- Ensure that there is more cohesive working with ITU and staff do not feel isolated or disjointed from the division.
- Ensure that there is an effective governance structure and system in place for the unit that feeds into the divisional governance structure.
- Ensure that the risk register reflects all their risks.
- Ensure that the intranet search facility is improved and staff can access clinical guidelines quickly.
- Ensure that there is an agreed strategy in place.

In Maternity:

The trust should:

- Ensure good hand hygiene is fully embedded so all staff clean their hands before and after patient contact.
- Seek to minimise delays in transferring women to the delivery suite to avoid compromising women's privacy and dignity through labouring in the antenatal ward or triage.

In End of life care:

The trust should:

- Ensure the service begins a programme of auditing of key safety measures for end of life patients.
- Ensure that patients are receiving mental capacity assessments where necessary and that these are documented in patient records.
- Ensure that all staff are trained in the use of syringe pumps where necessary.
- Ensure that the bereavement service is available to patients and there is adequate space to have private conversations.

In Outpatients:

The trust must:

- Ensure the laser service meets all the requirements set forth in the Medicines and Healthcare Products Regulatory Agency safety standards.
- Ensure that clinical records are maintained in an orderly, clear and legible manner and that this is checked on a regular basis.

The trust should:

Summary of findings

- Address the large backlog of estates maintenance in a prompt manner and that any repair issues does not hinder the daily service operations.
- Address concerns regarding managerial duties for senior nurses in times of staff shortages.
- Take stronger action to ensure that all shifts are filled and that extra bank staff be recruited to fill vacancies if required.
- Deal with divisional and departmental risks in a timely manner.
- Actively engage with staff and patients in order to drive service improvement.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at the trust as requires improvement because:

- Since our previous reports published in January and August 2015, when we highlighted the poor condition of the trust's buildings and estate, there had been little or slow progress in addressing this issue. The trust had been seeking external support for a new external build on an adjacent site. The trust's plans in this respect were not at an advanced stage.
- We found staff members operating within sub-optimal conditions, coping on a day to day basis in those conditions in the short term. Although they were doing the best they could in the circumstances, we saw examples of this environment impacting on patient experience and quality standards. We were not assured that the trust leadership fully appreciated the impact we saw due to the poor estate and environment. We found beyond this, staff had little opportunity themselves to develop the culture into one of continuous learning and improvement.
- The trust had the second highest backlog of estates maintenance issues in the country. The newly appointed director of estates was accomplishing a skilful role in overcoming serious faults which could potentially halt the trust's operation in several areas and at any time. While some members of the trust's board were aware of the risks of the poor estate and infrastructure we were not assured that all were fully sighted of the magnitude. We saw areas with patients having access to corridors which were sharing both clinical and service areas at the Hillingdon site, with patient clinic rooms adjacent to maintenance rooms. We also saw public access corridors with exposed cabling in the ceilings; ward and corridor windows which were regularly sealed with gaffer tape; window frames in otherwise adequate wards rotting, and ward flooring areas renovated piecemeal where previously leaking sinks had deteriorated the floor covering.
- The trust's vision and strategy document relied mainly on the option of providing a new acute health care facility off site without formally mentioning other options such as refurbishing the current estate even though we were told by senior leaders that this was an option if the preferred option did not materialise.
- We found that the trust's Board Assurance Framework (BAF) needed further development. Its content was lacking in detail; the structure was confusing, with in some cases no link between the trust's risks and strategy. There were no identified timescales, stated outcomes or allocation of responsibilities to individuals. We noted that although it was reviewed quarterly by the audit and risk committee the board only formally reviewed it twice per year.

Summary of findings

- The trust governors had belatedly begun to appreciate their role in presenting an effective challenge to the non-executive directors.
- Following on from the core service inspection, we found that four out of eight core services had improved from requires improvement to good but that four had not improved. We found that, despite being told of regular board to ward visits, board members did not appear to be sighted on serious issues we found in urgent and emergency care, surgery and outpatients which led us to take enforcement action.
- We could see that Fit and Proper Person (FPPR) and associated checks had taken place, but it was difficult for a third-party scrutineer to easily verify their completeness. The state of the records was generally untidy and needed further work in order for the trust to clearly demonstrate that they were complete.
- We noted that while the trust had taken the decision to reduce the frequency of board meetings to bi-monthly and that given the trust's quality and performance indicators, this did not assure us that the board were suitably sighted on the operational and quality issues.
- We were concerned that the medical leadership of the trust had not effectively addressed issues that we found in the core service inspection such as the management of sepsis, and inconsistent medical appraisal rates; and also with the nursing leadership over the management of deprivation of liberty (DoLS), duty of candour, the management of deteriorating patients, and lack of understanding of mental capacity act as examples.
- We found little acknowledgement of problems and ownership of concerns raised at interview with the nursing leadership, for example over issues we had found in infection, prevention and control.
- We were not assured that the trust's governance framework was sufficiently detailed to address the need to meet people's mental health needs and those with learning difficulties. We did not see a cohesive document in either the trust's annual report or strategy document that identified the overall accountability and accountable individual for cohesive provision for people with mental health needs and those with learning difficulties. We saw piecemeal reference to this provision in different documents.
- With reference to safeguarding we found that there was no effective governance in place to ensure patients subject to deprivation of liberty were reviewed, with the result that we found evidence of patients where a DoLS order had expired. There was no allegations policy in place. The trust did not always receive Section 42 reports from the local authority which meant that learning was not always shared. We found also that the trust safeguarding team was reliant on temporary staff to supplement the substantive lead nurses.
- There was no duty of candour policy to be easily found or easily visible on the intranet. The trust later told us that it was contained in other policies. The online electronic reporting system did not promote a duty of candour and did not have a trigger or an area to document that this duty had been applied from the outset. The trust later told us that duty of candour was considered at managerial level. We scrutinised six investigation reports into serious incidents that had occurred between 2016 and 2017, and we found some gaps in reference to it. Of the six, one made reference to duty of candour having been applied, which would be expected as part of the investigation process, and the remaining five made no reference.
- Leaders submitted notifications to external bodies as required. This included incident and serious incident reporting under the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (STEIS). In its latest annual report the trust reported one information governance category 2 breach following the theft of a trust encrypted laptop containing patient data. This was investigated by the Information Commissioner who found non-adherence to trust policies and procedures to safeguard information. We also noted that the trust failed to notify CQC of a recent Never Event. In preparation for our inspections, CQC analysts experienced difficulty in obtaining precise information requested and had to spend some time in explaining what was required whereas in other trusts this standard information was readily to hand.

Summary of findings

- In the trust latest published report and accounts (2016/2017) the board stated that it had mitigated concerns previously identified by CQC in its previous inspections. However in our latest core service inspection in March 2018 we found that this was not always the case.

However we also found areas of good practice:

- The trust board had the appropriate range of skills, knowledge and experience to perform its role. We found the non-executive directors to be high calibre and offering constructive and critical challenge to the executive board. Likewise the trust governors had recently found their requirement and ability to challenge the non-executive directors.
- The trust's vision and strategy presented a realistic vision reflecting the financial and estates pressures experienced by the trust. The strategy was aligned with local health and social care plans.
- Leaders within the service promoted a positive culture that supported and valued staff. Staff told us they were valued, supported and respected. There had been an improvement from the previous inspection where staff had reported low morale.
- We found a generally open and honest culture with better internal and external communication, and noted that there appeared to be a greater level of individual accountability at all levels from the more complacent attitude we found at the previous inspection. Staff felt able to raise concerns without fear of retribution. We found that the chief executive in particular was highly visible in the trust.
- We found staff to be dedicated and hard working. Staff were generally proud and happy to work in the trust and we saw examples of where staff members had previously left only to return to the trust. Staff were able to raise concerns without fear of retribution.
- We found that the trust leadership had embraced the concept of Freedom to Speak up Guardian and had offered support to the Guardian that they were satisfied with and would continue to provide further support when requested.
- The trust had in place a logical governance framework with clear management accountability at all levels. The triumvirate of clinical director, divisional director and head of nursing in each division was reflected at all levels and helped to facilitate effective collaborative working.
- Leaders regularly reviewed and improved the processes to manage current and future performance. The trust board attempted to provide assurance that the trust's statutory obligations as well as its overall performance was of the standard expected or that action was being taken to try to achieve compliance to those standards. It did this either directly or through its committee structure. Although we saw no evidence that financial pressures were impacting on care, finance was a major focus in trust committee discussions.
- We found that the trust leadership was willing to participate in new initiatives such as the Hillingdon Accountable Care Partnership bringing together other providers in the health, mental health, social care and voluntary sectors with the aim of providing more integrated care.
- We were impressed by the trust's People Strategy setting out key milestones for example recruitment and retention and succession planning. We saw that staff were encouraged to develop their skills and met several members of staff who had completed a Leadership in Action programme while at the trust. Performance management measures were in place where necessary.
- Although there were problems with local risk registers not always reflecting the concerns of staff, we found the trust corporate risk register to be a well-designed document clearly identifying risks, timescales and accountable individuals. Similar work was required to improve divisional and local risk registers.

Summary of findings

- The board received holistic information on quality and sustainability. Leaders used meeting agendas to address quality and sustainability sufficiently at all levels across the trust. Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care.
- IT systems and telephones were working well and they helped to improve the quality of care. Staff had access to the IT equipment and systems needed to do their work. During the previous financial year, the trust invested in a capital programme of £10.9 million on the facilities, equipment and technology used by staff for information and to deliver healthcare.
- The trust information team had undertaken a triangulation exercise in 2017, examining data sources that they regularly analysed for potential underlying issues of quality related to performance or quality. This was to assist the trust and trust board to be clear on its priorities and quality targets. The board and senior staff expressed confidence in the quality of the data and welcomed challenge.
- The trust actively sought to participate in national improvement and innovation projects. The trust stated the intention of strengthening the relationship with local academic partners, such as the local university, as well as with an academic health service network hosted by another London NHS trust, with the aim of creating an environment of innovation at the trust.
- Effective systems were in place to identify and learn from unanticipated deaths. The trust tracked HSMR monthly and had a mortality surveillance group reviewing deaths occurring in its hospitals. The trust had aligned its mortality review processes in line with the NHS England Framework on Learning from deaths published in March 2017.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate ↓ Jul 2018	Requires improvement ➔➔ Jul 2018	Good ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
The Hillingdon Hospital	Inadequate ↓ Jul 2018	Requires improvement →← Jul 2018	Good →← Jul 2018	Requires improvement →← Jul 2018	Inadequate ↓ Jul 2018	Inadequate ↓ Jul 2018
Mount Vernon Hospital	Requires improvement Oct 2014	Good Oct 2014	Good Oct 2014	Requires improvement Oct 2014	Requires improvement Oct 2014	Requires improvement Oct 2014
Overall trust	Inadequate ↓ Jul 2018	Requires improvement →← Jul 2018	Good →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for The Hillingdon Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓ Jul 2018	Inadequate Jul 2018	Requires improvement ↓ Jul 2018	Requires improvement →← Jul 2018	Inadequate ↓ Jul 2018	Inadequate ↓ Jul 2018
Medical care (including older people's care)	Good ↑ Jul 2018	Good ↑ Jul 2018	Good →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018
Surgery	Inadequate ↓ Jul 2018	Requires improvement →← Jul 2018	Good →← Jul 2018	Requires improvement →← Jul 2018	Inadequate ↓ Jul 2018	Inadequate ↓ Jul 2018
Critical care	Requires improvement →← Jul 2018	Good ↑ Jul 2018	Good →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018
Maternity	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Outstanding Jul 2018	Good Jul 2018
Services for children and young people	Good ↑ Jul 2018	Good →← Jul 2018	Good →← Jul 2018	Good ↑ Jul 2018	Good ↑ Jul 2018	Good ↑ Jul 2018
End of life care	Good ↑ Jul 2018	Good ↑ Jul 2018	Good →← Jul 2018	Good ↑ Jul 2018	Good ↑ Jul 2018	Good ↑ Jul 2018
Outpatients	Requires improvement Jul 2018	N/A	Good Jul 2018	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Overall*	Inadequate ↓ Jul 2018	Requires improvement →← Jul 2018	Good →← Jul 2018	Requires improvement →← Jul 2018	Inadequate ↓ Jul 2018	Inadequate ↓ Jul 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Mount Vernon Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement Oct 2014	N/A	Good Oct 2014	Requires improvement Oct 2014	Requires improvement Oct 2014	Requires improvement Oct 2014
Medical care (including older people's care)	Requires improvement Oct 2014	Good Oct 2014	Good Oct 2014	Requires improvement Oct 2014	Good Oct 2014	Requires improvement Oct 2014
Surgery	Requires improvement Oct 2014	Good Oct 2014	Good Oct 2014	Requires improvement Oct 2014	Requires improvement Oct 2014	Requires improvement Oct 2014
Outpatients and diagnostic imaging	Good Oct 2014	N/A	Good Oct 2014	Requires improvement Oct 2014	Requires improvement Oct 2014	Requires improvement Oct 2014
Overall*	Requires improvement Oct 2014	Good Oct 2014	Good Oct 2014	Requires improvement Oct 2014	Requires improvement Oct 2014	Requires improvement Oct 2014

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

The Hillingdon Hospital

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Key facts and figures

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

Hillingdon Hospital is an acute and specialist services provider in North West London, close to Heathrow Airport for which we are the nearest hospital for those receiving emergency treatment. Providing the majority of services from the Trust, Hillingdon Hospital is the only acute hospital in Hillingdon with a busy, , , and clinics.

The Hillingdon Hospital provide the following services:

- Urgent and emergency care
- Medical care (including older people's care
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

Summary of services at The Hillingdon Hospital

Inadequate  

Our rating of services went down. We rated them as inadequate because:

- There was a deterioration in infection prevention and control since the time of the last inspection. We found inconsistencies in hand hygiene practice amongst staff, during ward rounds.
- Medicines were not always appropriately stored or checked in emergency department (ED).

Summary of findings

- There was poor recognition of sepsis.
- There had been an improvement in safe levels of staffing although the trust needed to continue to work to increase substantive staff in post and reduce reliance on temporary staffing. Some services within the trust did not have enough permanent nursing and medical staff to ensure the provision of safe care and treatment. However, they used bank and agency staff to cover gaps in the staff provision.
- We found out of date copies of the major incident plan on some wards and this was against the trust's own policy.
- The trust had not improved in relation to the testing of portable electrical equipment. We found that not all portable appliances had been tested.
- We were not assured that high-risk patient groups were screened for MRSA at pre-admission.
- Staff did not always maintain appropriate records of patients' care and treatment. Records were not always clear, up-to-date and available to all staff providing care.
- We were not assured that the laser service met the Medicines and Healthcare Products Regulatory Agency safety standards.
- There was low participation in clinical audits and the trust performed poorly in some.
- Appraisal rates were low in some areas.
- Staff did not always understand their roles and responsibilities in relation to the Mental Capacity Act 2005, in particular in relation to Deprivation of Liberty Safeguards (DoLS).
- The trust did not audit the World Health Organisation (WHO) five steps to safer surgery in 2017.
- There were no pre-operative fasting audits for patients fasting before surgery.
- The trust did not always actively monitor the effectiveness of care and treatment and use this information to improve services.
- The trust did not meet the target to admit, discharge, or transfer and did not meet the standard that patients should wait no more than one hour for initial treatment.
- The A&E waiting area for patients who attended by their own means was very crowded with insufficient seating.
- We found that staff had poor awareness of the needs of people with learning disabilities.
- Translation services were not always offered to patients.
- The trust provided a range of information leaflets including support groups. However, similarly to the last inspection we did not see any information printed in any other language.
- Spaces within the were surgery division was not suitable for inpatients due to the lack of essential equipment and washing facilities.
- The trust's investigation and closure of complaints was not in line with their complaints policy which states complaints should be completed in 30 days.
- Since the last inspection, there had been limited improvement in the facilities on the ITU for relatives and visitors.
- There were limited examples of departments supporting patients to manage their own health.
- The bereavement service had limited opening hours and inappropriate waiting areas for bereaved family members
- There was a large backlog of estates maintenance.

Summary of findings

- Local risk registers did not always reflect risks described by staff in some areas.
- Matrons and managers within the trust did not have the capacity to effectively lead their teams due to pressures faced operationally.
- The senior management team had not taken note of all of the concerns raised at the previous inspection.
- We found that divisional and executive team were not visible in some areas and rarely some visited departments.
- Staff struggled to locate clinical guidelines quickly as the trust intranet search engine was not user friendly.
- The department had managers with the right skills to run the service; however senior nurses felt that their managerial duties were at times excessive of their role.
- We were not assured that there were adequate governance procedures for the laser service as set by the Medicines and Healthcare Products Regulatory Agency safety standards.

Urgent and emergency services

Inadequate 

Key facts and figures

The Hillingdon Hospital trust has a range of urgent and emergency care services based at two sites within the borough:

•Hillingdon Hospital

•Mount Vernon (minor injuries unit) - not inspected in this current inspection.

The emergency department is co-located alongside the urgent care centre at the Hillingdon Hospital site. It is open 24/7 and sees approximately 129,000 patients a year, which is an increase from 85,000 patients seen in 2013. The adult department has the capacity to care for patients in 27 trolley or bed spaces across three areas. Alongside the emergency department and the urgent care centre is a separate dedicated paediatric emergency department designed specifically for the needs of younger patients. Both the paediatric and adult emergency departments are consultant led.

The emergency department is divided into four key areas:

• The four bay resuscitation area for the most seriously ill or injured patient.

• The majors area is for the assessment and treatment of major illness.

• The paediatric emergency department which opened in July 2016 and sees all patients up to the age of 16.

• The clinical decision unit (CDU) which opened in January 2017 and accommodates seven bedded patients and five seated patients who require planned interventions and treatments for a period of no more than 12 hours to help facilitate the discharge of those patients that do not require admission.

The urgent care centre (UCC) is run by an independent healthcare provider and is designed to see patients that have an urgent condition or minor injuries. The UCC were not inspected as part of this inspection.

All patients of all ages who arrive at the hospital are screened by this service and directed either to the UCC where they will be seen by a GP or to the early first assessment and management (EFAM) which is run by the hospital trust. The EFAM is run by a consultant or middle grade doctor and a nurse. Patients are triaged by the UCC staff and dependent upon the outcome are directed to the resuscitation area, majors area or ambulatory pathways.

The department was previously inspected in May 2015 and was rated as requires improvement overall. It was rated requires improvement in safe, effective, responsive and well-led domains and good in caring domain.

We inspected the ED over three consecutive days on 6, 7 and 8 March 2018. We looked at 24 sets of adult patient records; 10 sets of paediatric patient records and six sets of records of patients who were on the mental health pathway. We spoke with 41 members of staff including doctors, nurses, managers, allied health professionals, support staff, administrative staff and ambulance crews. We spoke with 26 patients and 8 relatives who were in the department at the time of the inspection. We reviewed and used information provided by the trust in making our decisions about the service.

Summary of this service

Our rating of this service went down. We rated it as inadequate because:

Urgent and emergency services

- There was deterioration in infection prevention and control since the time of the last inspection.
- Medicines were not always appropriately stored or checked.
- The mental health interview room was not safe.
- Regular observations of patients were not carried out.
- There was poor recognition of sepsis.
- There was low participation in clinical audits and the trust performed poorly in some.
- There was poor assessment of patients' pain.
- The appraisal rate for doctors was 13%, which was below the trust standard of 90%.
- We observed some negative staff behaviour towards patients.
- There was poor communication with patients.
- The department did not meet the target to admit, discharge, or transfer 95% of patients within four hours between February 2017 and February 2018.
- The service did not meet the standard that patients should wait no more than one hour for initial treatment during this same time period.
- The waiting area for patients who attended by their own means was very crowded with insufficient seating.
- We found that staff had poor awareness of the needs of people with learning disabilities.
- Translation services were not always offered to patients.
- There were differences between the recorded risks on the risk register and what staff expressed was on their 'worry list'.
- There had been no significant improvement in the storage and checking of medicines since the last inspection.
- Junior doctors told us there were differences in consultant leadership and some were more supportive than others.
- Many staff told us they did not feel able to escalate their concerns about pressures of work and how this impacted on poor patient safety and experience.

However:

- The environment in paediatric ED was well maintained.
- Staff were confident about how to record incidents.
- Multidisciplinary working was evident in most areas of the department.
- Patients and carers in the paediatric ED and the CDU spoke very positively of their experiences.
- The department had a frailty pathway, supported by specialists, to safely reduce admissions and length of stay for elderly patients and ambulatory care pathways.
- There was a mental health matron seconded from a local trust who supported staff to offer a better patient experience to those with mental health issues.
- The trust was working alongside the NHS Improvement Emergency Care Improvement Programme Team (ECIP) to drive up standards and improve patient experience.

Urgent and emergency services

- Many staff told us that members of the operational team were visible and they could tell us who they were.
- Staff told us they enjoyed good local teamwork.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate because:

- At the time of the last CQC inspection in May 2015, some ED staff did not follow best practice with regards to hand hygiene and the use of personal protective equipment. We found this was still the case.
- We found many areas and pieces of equipment in an unhygienic state and most areas were untidy and dusty. Staff did not always decontaminate their hands between patients.
- During the last CQC inspection we found best practice was not always followed by all staff in relation to medicines, with daily checks occasionally not happening as necessary and some areas left unsecured. We found this to be still to be the case where controlled drugs were not always safely checked or stored in accordance with NICE guidelines.
- There were frequent occasions when the resuscitation area used a fifth bay which lacked piped oxygen or suction and patient privacy was compromised.
- Fridge temperatures in the resuscitation area were above the recommended safe storage temperature levels on several occasions with no actions recorded.
- The drug cupboard in the resuscitation area was disorganised and at times this made it difficult for staff to access emergency medicines.
- The environment of the general waiting area was a matter of concern. There was insufficient seating in relation to the volume and flow of patients, and we saw there was restricted space to manage a patient who collapsed in the waiting area.
- We were not assured that there was safe oversight of waiting patients which many staff agreed with.
- Paediatric patients were first checked in by reception staff untrained in paediatric care. There were occasions when they were directed to sit in the waiting area until seen by the streaming nurse which in the case of the deteriorating child, was a matter of concern.
- The mental health room was isolated from areas where other clinical staff were. Doors to the room were not anti-barricade doors, and furniture was not safe in the event of challenging behaviour. There were several ligature anchor points and many staff told us the room was not fit for purpose.
- There was a lack of clarity about whose responsibility those patients brought in by ambulance awaiting handover to emergency department staff were. This meant that there were no repeat observations done by either accompanying ambulance crew or trust staff.
- Ambulance crew told us they did not do repeat observations and hospital managers told us their understanding was that ambulance crew did observations until such time as the patient was transferred to a hospital trolley.
- Our review of some patient records indicated that there was a failure to recognise potential signs of sepsis and act on them. We saw no evidence of sepsis awareness protocol or posters on display. Sepsis training was included in staff induction but there was no provision made for further sepsis training.
- Early warning scores were not consistently recorded to recognise a deteriorating patient.

- There was a substantial number of outstanding electronically recorded incidents not reviewed or investigated.
- We found that patient records were in poor condition with loose sheets of paper which were not always collated in date order.
- There was an increasing number of occasions when patients waited over an hour from ambulance arrival at the emergency department until they were handed over to the emergency department staff (black breaches).

However:

- At the last inspection we found that compliance with mandatory training was low. At this inspection, there was improvement and compliance met the trust standard in most areas, including safeguarding adults and children training and infection prevention levels one and two. It was not clear from the way in which data was presented by the trust whether training was low for individual staff groups.
- We observed all staff to be compliant with bare below the elbows during our inspection days.
- The environment in the paediatric ED was clean and well maintained.
- There was an increase in nursing and medical staffing since the time of the last CQC inspection though this was not yet at full capacity.
- There was a robust induction process for agency nursing and medical staff.
- The trust recently recruited a bank of qualified mental health nurses, who were available to work in ED and across the hospital as needed.
- Staff were aware of how to report an incident on the electronic reporting system.

Is the service effective?

Inadequate 

This domain was not rated at the last inspection. We rated it as inadequate because:

- There was low participation in clinical audits and doctors told us the high volume of clinical work took priority over audit work.
- The trust failed to meet any of the standards for consultant sign-off audit and did not audit consultant sign off for non-traumatic chest pain or febrile children under 12 months old.
- The trust failed to meet any of the audit standards in the 2015/16 Procedural sedation in adults audit.
- The ED risk register included treatment of septic patients in ED as a moderate risk. It was noted that Royal College of Emergency Medicine Standards for severe sepsis and septic shock were not always met and septic patients might have delays in treatment leading to unfavourable outcomes.
- There was poor assessment of pain recorded on patient records.
- Junior doctors found it hard to access training due to pressure of work.
- The appraisal rate for medical staff was 13%, which was below the trust standard of 90%.
- Board rounds to discuss the patients in the department did not always happen and those we observed were poorly attended and disorganised.

- We observed a patient put into handcuffs without any apparent risk assessment or assessment of their capacity made at that time. The use of handcuffs as restraint was not included in the trust 'management of violence and aggression policy 2018'. We brought this incident to the immediate attention of the chief executive.

However:

- A folder on mental health resources was recently circulated within the ED department.
- Multidisciplinary working was evident in most areas of the department. The involvement of other teams such as the on-site psychiatric liaison team and frailty team helped to improve the patient experience.
- Trust data showed there was 83% compliance with MCA and DoLS training for emergency care staff which was above the trust standard of 80%.

Is the service caring?

Requires improvement 

Our rating of caring went down. We rated it as requires improvement because:

- We observed some negative staff behaviour towards patients.
- Patients told us they did not understand their journey through the treatment system, and there was no available information to help them.
- Patients in the waiting area struggled to get information about where they should go within the department or how long their wait was likely to be.
- There was a low response rate to the Friends and Family Test.
- The results of the CQC Emergency Department Survey 2016 showed that the trust scored worse than other trusts in 18 of the 24 questions relevant to caring.
- We observed several occasions when patient privacy and confidentiality was compromised.
- Patients were seated in wheelchairs or on trollies in close proximity in a corridor area whilst they waited for a free bay in ED majors.
- Patients told us they observed verbal clashes between doctors and nurses which they found unsettling.
- Patients had to wait for pain relief medicine on occasion.

However:

- Patients and carers in the paediatric ED and the CDU spoke very positively of their experiences.
- We observed some positive interactions between patients and staff.

Is the service responsive?

Requires improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

Urgent and emergency services

- The department did not meet the target to admit, discharge, or transfer 95% of patients within four hours between February 2017 and February 2018. The percentage of patients discharged within the time standard varied between 40% and 60% where the national average was 76%.
- The service did not meet the standard that patients should wait no more than one hour for initial treatment. The average waiting time was 98 minutes between February 2017 and February 2018.
- The waiting area for patients who attended by their own means was over crowded with insufficient seating which made for a stressful experience for patients and people were not kept informed about waiting times.
- There was no clearly defined area in which children and their carers could wait separately from adult patients. This contravenes Royal College of Paediatrics and Child Health Standards for Children and Young People in Emergency Care Settings 2012.
- We were told that there were times when it was difficult to get patients accepted from streaming into the ED due to high numbers of patients.
- There was no oversight maintained of those patients who were referred directly into the EFAM queue.
- We found that staff had poor awareness of the needs of people with learning disabilities.
- There was no record of comfort round checks on any of the patient records we reviewed despite many patients being in the department between nine and 15 hours.
- We observed occasions when patients whose first language was not English struggled to be understood but were not provided with translation support.
- The trust took an average of 37 working days to investigate and close complaints, which was not in line with their complaints policy, which states complaints should be completed in 30 days.

However:

- The service met the standard that patients should wait no more 15 minutes for an initial assessment every month between February 2017 and February 2018.
- The percentage of patients who left before being seen was 2.3%, which was better than the England average of 2.5%.
- There was a new role of flow coordinator within ED majors introduced in November 2017.
- The department had a frailty pathway, supported by specialists, to safely reduce admissions and length of stay for elderly patients and ambulatory care pathways.
- Patients in the CDU spoke positively of their treatment there.
- There was a mental health matron seconded from a local trust who supported staff to offer a better patient experience to those with mental health issues.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate because:

- We were not assured there were clear responsibilities, roles and systems of accountability to support good governance and management.

- There were differences between the recorded risks on the risk register and what staff expressed was on their 'worry list'.
- There was no plan in place to mitigate the risk of the outstanding number of unreviewed incidents on the electronic incident reporting system.
- Many of the problems identified at the last inspection had not been addressed by the leadership including the following:
- There was deterioration in infection prevention and control since the last inspection.
- There was deterioration in the storage and checking of medicines since the last inspection.
- There had been no significant improvement in the level of mandatory compliance since the last inspection.
- Many staff told us that the trust leadership was target driven with pressure channelled downwards to staff at a local level.
- Many staff told us they did not feel able to escalate their concerns about pressures of work and how this impacted on poor patient safety and experience.
- There was reduced participation in the national audit programme.
- There was uncontrolled public access to most areas of the department.
- The response rate from staff in ED to the 2017 staff survey was lower than the rest of the hospital at 38% compared with 53%.
- Junior doctors told us there were differences in consultant leadership and some were more supportive than others.

However:

- The trust was working alongside the NHS Improvement Emergency Care Improvement Programme Team (ECIP) to drive up standards and improve patient experience.
- Members of the operational team were visible and engaged and many staff could tell us who they were.
- Staff told us they enjoyed good local teamwork.
- Trust values were clearly on display and most staff were familiar with them.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Medical care (including older people's care)

Requires improvement 

Key facts and figures

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

Endocrinology, rheumatology, and haematology.

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

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

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

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

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

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

Admissions for the top three medical specialties were:

- Gastroenterology; 7,516
- General Medicine; 5,180
- Pain Management; 3,083

(Source: CQC Insight)

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

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

We inspected Hillingdon Hospital in 2014 and rated medical care as requires improvement overall. This reflected a rating of inadequate for safe, good for caring and requires improvement for effective, responsive, and well led. We inspected medical care again in 2015 and focused only on the safe domain. The rating for safe improved to requires improvement. The rest of the domains remained the same (good for caring and requires improvement for effective, responsive and well led).

Medical care (including older people's care)

Summary of this service

Our overall rating of this service following our latest inspection stayed the same. We rated it as requires improvement because:

- The service had systems and processes to keep people safe and safeguard them from abuse and staff understood these processes.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Senior staff investigated incidents and shared lessons learnt with staff.
- There had been an improvement in relation to safety monitoring and the collection and display of safety information on the wards.
- There was consistent and effective use of National Early Warning Scores (NEWS) including appropriate escalation.
- Overall, there had been an improvement in medicines management on the medical wards.
- There had been an improvement in systems and processes around cleanliness, infection control and hygiene.
- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Overall, the service made sure staff working on the various wards were competent for their roles.
- The service monitored the effectiveness of care and treatment and used the findings to improve them with notable performance improvements in some national audits.
- Staff from different staff groups and teams worked together to deliver care and treatment.
- Staff cared for patients with compassion, dignity, kindness and respect and involved patients and those close to them in decisions about their care and treatment.
- The service had improved its discharge processes in order to improve flow within the hospital.
- The service had taken action to minimise the length of time people waited for care and treatment using initiatives such 'Discharge to Assess' and 'Home Safe'.
- From December 2016 to November 2017 the trust's referral to treatment time (RTT) for open or incomplete pathways for medicine ranged from 88-98% and was better than the England average for nine out of the 12 months.
- The values of the trust were embedded and staff at all levels were able to tell us what the trust values were and how they applied to their roles.
- There was alignment between what leadership said the risks were and what we found during the inspection.
- Leaders promoted a positive culture that supported and valued staff.
- Quality and safety received sufficient coverage in board meetings, and in other relevant meetings below board level. There was a culture of honesty, openness and transparency. We saw evidence of senior staff carrying out duty of candour responsibilities.

However:

- There had been no improvement in relation to safe levels of staffing. The service did not have enough permanent nursing and medical staff to ensure the provision of safe care and treatment. However, they used bank and agency staff to cover gaps in the staff provision. Although the service had taken action to address staff shortages, those actions had to date not resulted in improvements in staff numbers.

Medical care (including older people's care)

- Staff did not always keep appropriate records of patients' care and treatment, for example dementia, bed rails and mental capacity assessments.
- We found out of date copies of the major incident plan on some wards and this was against the trust's own policy.
- Six out of 13 mandatory training modules failed to meet the target completion rate.
- The service had not improved in relation to the testing of portable electrical equipment. We found that not all portable appliances had been tested.
- Staff did not always understand their roles and responsibilities in relation to the Mental Capacity Act 2005, in particular in relation to Deprivation of Liberty Safeguards (DoLS).
- Despite various actions and initiatives to improve access and flow, the hospital still experienced a high demand for beds with bed occupancy rates of between 97% and 98% during the three days of our announced inspection.
- Matrons and managers within the service did not have the capacity to effectively lead their teams due to pressures faced operationally. Although the trust had systems for identifying risks and plans to mitigate risks, this did not always translate to improvements within the service.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- The service had systems and processes to keep people safe and safeguard them from abuse and staff understood these processes. Staff had training on safeguarding patients, were knowledgeable about the safeguarding processes and worked well with external agencies. All three safeguarding modules met the trust target.
- Overall, the service prescribed, gave, recorded and stored medicines well. There had been an improvement overall in relation to medicines management on the medical wards. In 2014, we found that not all trolleys were checked daily. There had been an improvement in relation to this and we found that staff checked resuscitation trolleys.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Senior staff investigated incidents and shared lessons learnt with staff in order to improve the service. We found a culture of incident reporting and evidence of learning from incidents.
- There had been an improvement in relation to safety monitoring. Staff collected and displayed safety information on the wards and service used information to improve the service. Following the 2014 inspection, we reported that the service had not always displayed safety thermometer results on the wards.
- Staff assessed and responded to deteriorating patients well. We found evidence of consistent and effective use of National Early Warning Scores (NEWS) including appropriate escalation.
- The service had improved in how it managed patients' individual care records, including clinical data. When we inspected in 2014 we found that records were not always stored securely, however, during this inspection we found that staff kept patient' records securely.
- There had been an improvement in systems and processes around cleanliness, infection control and hygiene. For example, in 2015 we found that the service did not always carry out infection control audits such as hand hygiene, and bare below the elbow audits. On this inspection, we found that the service had carried out these audits and used them to identify areas requiring improvements.

- There had been an improvement in therapy staff access to equipment. Therapy staff reported they had sufficient computers. A lack of computers for therapy staff had been concern at the previous inspection

However:

- The service did not have enough permanent nursing and medical staff to ensure the provision of safe care and treatment. However, the service used bank and agency staff to cover gaps in the staffing provision.
- Staff did not always keep appropriate records of patients' care and treatment. Staff did not always complete dementia or bed rail assessments. The completion of records was inconsistent across the medical wards. Staff used different documents to record sepsis management showing lack of consistency in recording patient information.
- The service planned for major incidents and staff understood their roles if one should happen but we found out of date copies of the major incident plan on some wards.
- The service provided mandatory training in key skills to all staff but six out of 13 mandatory training modules failed to meet the target completion rate.
- The service had not improved in relation to the testing of portable electrical equipment. We found that not all appliances had been tested. We made similar findings at the previous inspection.
- The trust did not have a named individual as the authorised person or competent person for endoscopes. This is an individual trained and qualified to ensure all endoscope machines are commissioned to HTM01-01: Decontamination of reusable medical devices (health test memorandum–HTM).

Is the service effective?

Good ↑

Our rating for effective improved. We rated it good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. A clinical audit and effectiveness committee checked the use of evidence based care and treatment within the service.
- Overall, the service made sure staff were competent for their roles. There was evidence of the critical care outreach team working with staff on specialist wards to improve competencies. Furthermore, from April 2017 to November 2017, 95% of staff within medicine at Hillingdon Hospital had received an appraisal. Staff reported that they received supervisions from their managers and other seniors
- The service monitored the effectiveness of care and treatment and used the findings to improve them. The service took part in local and national audits and there had been an improvement in relation to performance on some national audits.
- In the Sentinel Stroke National Audit Programme, the service obtained a rating of B (on a scale of A-E, where A is best) in the latest audit. This was an improvement on the previous submission where the service achieved grade C.
- The service's results in the 2016 Heart Failure Audit were better than the England and Wales average for all four of the standards relating to in-hospital care. Results were also better than the England and Wales average for five of the seven standards relating to discharge.
- From September 2016 to August 2017, patients at Hillingdon Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.

Medical care (including older people's care)

- Staff from different staff groups and teams worked together to deliver care and treatment. We saw evidence of nurses, doctors, therapy staff, allied health professionals working together to provide good care.
- There had been an improvement in relation to the provision of seven-day services. An ambulatory care unit provided a seven-day service to help avoid unnecessary admissions. In radiology, the service used an external organisation to cover radiology out of hours.

However:

- Staff did not always understand their roles and responsibilities in relation to the Mental Capacity Act 2005.Staff did not always understand the reasons why patients were subject to Deprivation of Liberty Safeguard (DoLS) and DoLS paperwork was not always completed fully or placed in the patients' records.
- There had been no improvement in relation to checking agency staff competencies. Senior staff did not always complete competency checklists for agency staff. We were therefore not assured that agency staff working on the wards were competent to do so.
- From September 2016 to August 2017, patients at Hillingdon Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.
- Staff did not always complete bed rail and dementia assessments.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Staff treated patients and their families with dignity, kindness and respect. We observed positive and compassionate interactions between staff and patients.
- Staff involved patients and those close to them in decisions about their care and treatment. The majority of patients we spoke with spoke positively about their experiences of and involvement in their care.
- The Friends and Family Test is a measure of patient satisfaction. Findings showed patients would recommend the service to others.
- Patients told us that staff provided them with emotional support to when they felt distressed.

Is the service responsive?

Requires improvement ➔➔

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Despite various actions and initiatives to improve access, the hospital still experienced high demand for beds from patients coming in from the Accident and Emergency department (A&E). Bed occupancy during the three days of our inspection ranged between 97% and 98%.
- The aging estate did not always provide the best environment for providing care. Some ward areas were small and other ward areas had been divided into two beds where there would normally be one.

Medical care (including older people's care)

- In the Acute Medical Unit (AMU), some bed bays had been divided to create two beds where there would normally be one. This meant that only one of the two beds had an oxygen port and a call bell. At the time of the inspection each of the four bays in AMU had an extra bed.
- Although the service had guidance and processes for caring for patients with a learning disability, we saw one example of where staff had not managed a patient with learning disability well. They had not asked the patient's carer for a patient passport or given them one. A patient passport would have helped improve this patient's care in the hospital.
- From October 2016 to September 2017, the average length of stay for medical elective patients at Hillingdon Hospital was 10.1 days, which is higher than England average of 4.2 days. For medical non-elective patients, the average length of stay was 7.8 days, which is higher than England average of 6.6 days.

However:

- Although the service experienced increasing demand for its inpatient services, it planned services to ensure it met the needs of local people. Following the previous inspection in 2014, the service had opened a new ambulatory care unit to avoid unnecessary admissions. We also found that the service effectively worked with community partners in planning and providing services.
- Following our inspection in 2014 a new 29-bedded Acute Medical Unit had been opened and had increased beds available to patients coming in from the Accident and Emergency department (A&E).
- The service had improved its discharge processes in order to improve flow within the hospital. Clinical site practitioners worked towards ensuring patients were allocated a bed on the wards that best met their needs. We observed effective board rounds where patients ready to be discharged were identified. A discharge coordinating team worked with staff on the wards and helped with complex discharges.
- The service had taken action to minimise the length of time people waited for care and treatment. The 'Discharge to Assess' and 'Home Safe' initiatives allowed appropriate patients to be discharged home early to receive treatment or care in the community thus freeing up beds for other patients to access.
- There had been an improvement in how the service worked with other services in order to meet the demands of the local people. We found that there was a strong focus on coordinating care and treatment with other services and providers and we saw evidence of coordination between the service and its community partners.
- Overall, the service was coordinated to take account of the needs of different people. Staff had received training to care for the elderly and there was a mental health matron working within the service. Patients had access to translation services and relatives of patients living with dementia could stay overnight.
- From December 2016 to November 2017 the trust's referral to treatment time (RTT) for open (incomplete) pathways for medicine ranged from 88-98% and was better than the England average for nine out of the 12 months.

Is the service well-led?

Requires improvement 

Our rating of well led stayed the same. We rated it as requires improvement because:

- Although there had been improvements in managing patient access to services and flow within the hospital, demand remained high and the service operated at maximum capacity. To mitigate this, escalation beds had remained open indefinitely.

- Matrons and managers within the service did not have the capacity to effectively lead their teams due to pressures faced operationally, for example constantly having to cover gaps in the staffing.
- Although the service had taken action to address staff shortages, those actions had to date not resulted in improvements in permanent staff numbers. There were high nursing vacancies within the service.
- Although the trust had systems for identifying risks and plans to mitigate risks, this did not always translate to improvements within the service. For example, there were inconsistencies in relation to document completion across the wards and we found out of date major incident plans on the wards despite the risk register identifying risks related to incomplete and out of date documentation.
- Systems and processes around the management of patients subject to Deprivation of Liberty safeguards were not effective.

However:

- The values of the trust were embedded and staff at all levels were able to tell us what the trust values were and how they applied to their roles.
- Following the 2014 inspection, we reported that senior staff were not always aware of risks affecting the service. However, during this inspection we found that leadership were aware of the risks within the service. There was alignment between what leadership said the risks were and what we found during the inspection.
- Leaders within the service promoted a positive culture that supported and valued staff. Staff told us they were valued, supported and respected. There had been an improvement from the previous inspection where staff had reported low morale.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services.
- Quality and safety received sufficient coverage in board meetings, and in other relevant meetings below board level as evidenced by the meeting minutes we saw during and following the inspection.
- There was a culture of honesty, openness and transparency. We saw evidence of senior staff carrying out duty of candour responsibilities.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Surgery

Inadequate 

Key facts and figures

We inspected surgery at Hillingdon Hospital and used all of our key lines of enquires to determine whether this core services was safe, effective, caring, responsive and well-led.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

Our inspection was comprehensive and we visited pre-admission, surgical assessment unit, female day care unit, all seven theatres, Kennedy ward, Jersey ward and Pagett ward. We spoke with over 50 staff members of staff, including registered nurses of all bands, doctors, allied health professionals, pharmacists, managers, executive staff and admin staff. We had an Expert by Experience on our team and together we spoke with 25 patients and six patient relatives. Experts by Experience are people who have experience of using services or caring for someone who uses health and/or social care services.

We also used information provided by the organisation and information we requested following our inspection.

Summary of this service

Our rating of this service went down. We rated it as inadequate because:

- Safeguarding Children (level 2) failed to meet the trust target.
- The surgical assessment unit (SAU) was dividing singular bed spaces into two patient bed spaces, with the use of screens. This meant that only one patient had access to oxygen, call bells and suction.
- Staff we spoke with were not aware of the sepsis six (bundle of medical therapies) and we could not locate a screening tool for sepsis.
- We were not assured that high-risk patient groups were screened for MRSA at pre-admission.
- The hospital did not audit the World Health Organisation (WHO) five steps to safer surgery in 2017.
- Similarly to the last inspection we found five of the 13 mandatory training modules failed to meet the trust target, including manual handling which we observed to be very poor.
- There were no pre-operative fasting audits for patients fasting before surgery.
- DoLs (Deprivation of liberty) had been put in place for three patients without a DoL's assessment.
- The hospital provided a range of information leaflets including support groups. However, similarly to the last inspection we did not see any information printed in any other language.
- Similarly to the last inspection many spaces within the surgery division were being used to house inpatients, this included the female day care unit, recovery and the day room in Kennedy. These facilities were not suitable for inpatients due to the lack of essential equipment, and washing facilities.
- Staff in recovery were not trained to discharge patients, for example providing patients with 'to take away' medications which caused delays.

Surgery

- The trust took an average of 51 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed in 30 days.
- Executive staff told us that issues that arose out of hours were not always addressed with appropriately. Problems were dealt with in the moment with little forward planning.
- Staff reported that staff retention was low and that this was linked to poor relationships with management.
- Staff reported that they were often left without senior management and “no one in charge”.

Is the service safe?

Inadequate  

Our rating of safe went down. We rated it as inadequate because:

- Similarly to the last inspection we found wards had dust and odours and cleaning could not be effective due to the state of the flooring.
- Gaffer tape was still being used to prevent draft in the wards and in one theatre.
- There was still insufficient storage in theatres in theatre corridors.
- The resuscitation trolley was taken out of the recovery area when the hospital performed elective cardioversions, which meant that recovery did not have access to a resuscitation trolley when these elective surgeries were booked in.
- The surgical assessment unit (SAU) was dividing singular bed spaces into two patient bed spaces, with the use of screens. This meant that only one patient had access to oxygen, call bells and suction.
- Staff we spoke to were not aware of the sepsis six bundle of therapies and we could not locate a screening tool for sepsis.
- We were not assured that high-risk patient groups were screened for MRSA at pre-admission.
- There was an improvement on formal briefings, as per the WHO guidelines, that were conducted before the start of a trauma list. However similarly to the last inspection we found debriefings were not as formal and we observed consultants and anaesthetics leaving the meeting before it had finished.
- Similarly to the last inspection we found five of the 13 mandatory training modules failed to meet the trust target, including manual handling which we observed to be very poor.
- Similarly to the last inspection we found staffing throughout the division was low, which impacted on patient care, discharges and patient flow.
- Doctors were often pulled out of their mandatory training due fill shifts, which meant that some doctors we spoke with had not even completed their induction training.
- Some junior doctors felt pressured to swap their days off when their mentoring consultant was on call as they were expected to be present. This meant that some junior doctors were working seven, eight or nine days in a row. This resulted in doctors working above and beyond the expected safe working hours.
- In general surgery patient record folders were not well kept and the older the file, the more unkempt the folder appeared. We found a set of patient stickers in one set of notes belonging to a different patient.

Surgery

- The pharmacy staff checked (reconciled) patients' medicines on admission to wards; however; the hospital only did this check for 50-60% of patients within 24 hours of admission to hospital. There was no medicine reconciliation documented on six out of six prescription charts seen in the female day care unit.
- Incident reporting forms did not reference a duty of candour and there was poor knowledge of this duty in pre-assessment.
- The most recent never event that occurred within surgery was a retained swab inside a patient post surgery. This never event had also occurred in the reporting period of our last inspection.
- Theatre ventilation had improved since the last inspection but only adhered to 2005 guidelines.

However:

- Unlike the last inspection the risk assessments including; VTE assessments, manual handling, pain, water-low score, pressure ulcers, malnutrition was well done and clearly documented in patient records.
- All patients had national early warning scores and staff we spoke to were clear on the process of escalation.
- All equipment in theatre now conformed with the national safety standard and aesthetic equipment complied with the Association of Anaesthetics of Great Britain and Ireland (AAGBI) guidelines for checking anaesthetic equipment 2012. This was an improvement since the last inspection.
- We observed the World Health Organisation (WHO) five steps to safer surgery checklist completed before each surgery.
- Weekly teachings were available for all doctors in this division.
- Medicines, including controlled drugs, were securely stored and staff checked stocks of both medicines and controlled drugs (CD) daily. This was an improvement since the last inspection.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- Staff we spoke to was not aware of any pre-admission policy in place.
- The hospital did not ask patients to stop certain blood pressure medication as per national guidelines, before surgery.
- Staff we spoke to in pre-assessment said that there was no time to write a policy or to look up a policy on the computer, and that this was a job for a band seven.
- Senior staff told us that the surgery division did not undertake any benchmarking exercise with other similar services.
- The hospital did not audit the World Health Organisation (WHO) five steps to safer surgery in 2017.
- An audit on clinical effectiveness found that care plans were not completed properly; mitigating solutions were documented but not put in place.
- There were no pre-operative fasting audits for patients fasting before surgery.
- Patients at Hillingdon Hospital had than higher expected risk of re-admission for elective admissions when compared to the England average.

Surgery

- The length of stay was 30.2 days for general surgery for elective patients, which fell into the bottom 25% of trusts for performance.
- There were no competencies specifically designed for discharging patients. Staff could watch one discharge and then perform a discharge themselves.
- Similarly to the last inspection, medical staff had the lowest completion rate for appraisals of 39%.
- Similarly to the last inspection there was limited senior nursing support out of hours. The critical care outreach team provided support from Monday to Friday 8am to 5pm. Staff had access to a clinical site practitioner and staff reported that their main focus was on bed management.
- We found a resource folder on Jersey ward, which held information on safeguarding, female genital mutilation, preventing, modern slavery, mental capacity act and deprivation of liberty (DOLs). However when we asked the senior staff about the contents of the folder staff were unable to assure us of their knowledge on these areas and informed us that the folder had been newly introduced.
- Staff we spoke with told us that they had not received dementia training.

However:

- Peer audits took place between each theatre and a band seven was responsible for this.
- We saw checklists in the anaesthetic room that showed safety guidelines for anaesthetic equipment in line with the Association of anaesthetics of Great Britain and Ireland (AAGBI).
- There was good documentation for recording pain. Patients we spoke with told us that there was good pain management.
- Patients at Hillingdon Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- We saw positive and effective multidisciplinary working on the ward and documented in patient notes which was similar to the last inspection.
- The trust had a formal agreement with another trust for patients requiring interventional radiology out of hours or at the weekend. The two consultants employed by the trust for interventional radiology had an agreement that they will not be off at the same time. This was an improvement since the last inspection
- The hospital had carers passports for relatives who had patients with dementia on the wards.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff generally appeared caring, polite and compassionate.
- We observed a HCA explain to a patient in a polite manner why they had not been able to give them a wash in the morning, and inform the patient of when they were going to do this.
- We saw a patient being assisted to sit in a more comfortable position with the use of pillows.
- A patient we spoke with in Jersey ward told us that they had been looked after well.

Surgery

- We observed patient centred care and patient dignity preserved as much as possible during surgeries.
- We saw staff providing explanations of procedures and reassurance to patients who required this.
- Patient relatives we spoke with were happy with the care given to their relative. One relative said that staff were friendly and caring and 'can't do enough for you'.
- Relatives were happy with the communication and information given to them from staff.

Is the service responsive?

Requires improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The hospital provided a range of information leaflets including support groups. However, similarly to the last inspection we did not see any information printed in any other language.
- Similarly to the last inspection many spaces within the surgery division were being used to house in patients, this included the female day care unit, recovery and the day room in Kennedy. These facilities were not suitable for inpatients due to the lack of essential equipment and washing facilities.
- Tests for dementia were only performed on patients over 75 that presented with a neck of femur fracture. No other patients qualified for this test.
- Similarly to last inspection patient flow throughout the division was poor. We observed a theatre porter waiting for 15 minutes in Kennedy ward before he could take the patient down to theatre, due to lack of staffing assistance.
- Similarly to the last inspection the hospital did not comply with the national guidance issued by the Association of Anaesthetists of Great Britain and Ireland, in relation to the recovery room facility. This guidance recommends that the ratio of beds to operating theatres should not be less than two.
- Staff in recovery were not trained to discharge patients, for example providing patients with 'to take away' medications which caused delays.
- The Referral to Treatment Time (RTT) which is measured nationally as the percentage of the total number of patients on the elective waiting list under 18 weeks was at 88.8% in March 2018, the national standards target is set at 93%.
- The trust took an average of 51 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed in 30 days.

However:

- We observed patient's dietary needs and fluid restrictions clearly displayed above patients beds.
- We observed patient warming blankets in date and available for patients during surgery.
- The hospital also set up ambulatory care, which is when a patient can recover at home and return to the hospital for a follow up appointment, this helps to release hospital beds.
- In Q2 2017/18, this trust cancelled 44 surgeries. Of the 44 cancellations 0% weren't treated within 28 days.

Surgery

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate because:

- Many of the issues raised at the last inspection had not been addressed or improved by service leaders.
- Staff in the divisional management team told us that issues that arose out of hours were not always addressed with appropriately. Problems were dealt with in the moment with little forward planning.
- Staff on the wards reported that when issues were raised to management staff in the division they were shut down.
- Staff reported that management would often say that there was a bed crisis across the country; that there were no other alternatives and that staff needed to pull together.
- Staff reported that executive staff had limited discretion to act to resolve issues.
- Staff reported that staff retention was low and that this was linked to poor relationships with management.
- Staff stated reported that they were often left without senior management and “no one in charge”.
- Staff on Kennedy ward was not aware of who the executive staff of the division were.
- The values were not embedded into staff culture and staff struggled to recall the CARES acronym.
- Staff in pre-admission had particularly low morale and would answer a lot of our questions by saying that it was not in their job description.
- Pre-admission staff could not recall their latest incident, and did not have strong governance structures in place.
- The hospital did not audit compliance with the WHO five steps to safer surgery in 2017.
- Not all risks identified during the inspection were recorded on the risk register. This included the preoperative fasting audits and the lack of resuscitation trolley on certain days in recovery.

However:

- Staff in theatre reported a positive relationship with their manager and described their manager as good.
- Staff we spoke with felt that the hospital was a good place to work.
- Theatres held daily staff meetings that cascaded new information to the team; including trust agendas, infection control and improving everyday practice.
- Theatres won an internal award for ‘team of the year’.
- In the theatres staff room we saw learning from recent incidents displayed on notice boards.
- We spoke to a domestic staff who was recognised for their patient care and won an ‘award in compassionate care’ last year.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Critical care

Requires improvement 

Key facts and figures

The critical care department at the Hillingdon Hospital provides nine beds including, five level three intensive treatment unit (ITU) beds and four level two high dependency unit (HDU) beds.

The department provides care for both pre-booked (post-operative patients requiring high dependency care) and emergency admissions from the wards and emergency department.

In April 2016 to March 2017, there were 432 admissions and 358 discharges from the critical care unit.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

We visited the critical care department over three days. We spoke with 33 staff including consultants, nurses, allied health professionals, clerical and admin staff and managers of the service. We also spoke with three patients and 10 relatives who used the service. We observed care and treatment and looked at nine patient records and prescription charts. We also visited the theatre recovery area where HDU patients were cared for. We observed how staff were caring for patients and looked at the quality of the environment. We reviewed a variety of hospital data including meeting minutes, policies and performance data.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- We rated safe, responsive and well-led as requires improvement, and effective and caring as good.
- The rating for effective improved since the last inspection; the rating for each of the other key questions remained the same.
- The senior management team had not taken note of all of the concerns raised at the previous inspection and only made improvements in the areas of 24 hours consultant cover, healthcare assistant recruitment, partial improvement of the ventilation system and submission of the Intensive Care National Audit and Research Centre (ICNARC) data.
- There were no formal morbidity and mortality meetings. Learning from any clinical case presentations was not shared with the wider directorate, or fed back to the board through any identifiable governance structure.
- At the time of inspection, the unit was unable to provide optimal care for patients requiring isolation facilities such as positive and negative air pressure management. There was increased risk of cross infection, as at the time of our inspection; the ITU environment was not compliant with recommended building (HBN04-02) standards and heating and ventilation for health sector building (HTM 03-01) standards. We found inconsistencies in hand hygiene practice amongst staff, in particular during ward rounds. There was dust on some equipment and high surfaces. This remained an area of concern from the time of the last inspection.
- We found inconsistencies in the daily checks of the difficult airway/ intubation trolley in the located in the unit. Nursing staff equipment competencies for some key pieces of equipment had not been rechecked since 2015 and were now overdue.
- In the ITU, oxygen was not prescribed on the patient prescription chart as per the trust policy on the prescribing and administration of oxygen in adults.

Critical care

- In February 2018, the nursing vacancy rate was 16%. Staff informed us that due to increased bed pressures recently, there had been many occasions when the supernumerary nurse would cover the short staffed/unfilled shifts. There was no 24-hour cover provided by the critical care outreach team (CCOT). This was an area of concern at the last inspection.
- The unit did not use any sepsis screening tool and there was no separate policy for sepsis management in place. Although the outreach team told us that sepsis was part of the deteriorating patient policy. All junior staff we spoke with were not aware where to find information on sepsis management and if there was trust lead for sepsis.
- The unit was not meeting the Core Standards for Intensive Care Units recommendation of having a practice nurse educator, who dedicated two-thirds of their time to this role. This was an area of concern at the last inspection and we found no improvement in regards to this provision.
- The unit had made no progress in relation to the facilities for patients and relatives. There was only one patient toilet in the unit and no bath or shower facilities. Since the last inspection, there had been limited improvement in the facilities on the unit for relatives and visitors.
- Capacity and flow was one of the key areas of concerns for the unit. According to ICNARC data covering April 2016 to March 2017, the percentage of bed days occupied by patients with discharge delayed more than 8 hours and 24 hour was higher compared to other similar unit.
- We found that divisional and executive team were not visible and rarely visited the unit. The staff told us that there was little support for the critical care unit within the trust; they felt isolated and disjointed from the division. At the time of the last inspection, we found that there was no evidence of strong critical care leadership to challenge or influence the future direction of the service. At this inspection, we found there was still lack of any consensus regarding cohesive future direction of the service.
- There was a lack of an effective governance structure driven by the unit leadership team. Not all the junior staff we spoke with could articulate the department governance arrangements and how it fed into the divisional governance structure. Not all risks identified by us during the inspection were reflected on the risk register. In addition to this, many risks identified at the last inspection were still outstanding.
- Staff struggled to locate clinical guidelines quickly as the trust intranet search engine was not user friendly.

However:

- Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk, or had been exposed to abuse. There was a clear and effective process to ensure that potential safeguarding concerns were escalated.
- The service used safety monitoring results well. The unit now monitored incidents of falls, pressure ulcers, venous thromboembolism (VTE), central venous catheter infections and catheter associated urinary tract infections (UTIs). This information was displayed in both the staff room and on noticeboards within the unit. This had improved since the last inspection.
- The unit had made progress with regard to consultant cover and now had a separate on-call rota.
- Since the last inspection, the unit had made improvement and was now contributing data to the Intensive Care National Audit and Research Centre (ICNARC).
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Critical care

- At a local level, there was clear leadership for both medical and nursing staff. The lead consultant and unit manager worked closely together. They were both visible in the department and junior clinical staff described them as approachable and supportive.
- We saw collaborative working between clinicians. Junior doctors and nurses felt supported, with regular supervision. We saw that the medical team worked well together, with consultants being available for junior doctors to discuss patients and to give advice where needed.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support. At the time of last inspection, we found that there was limited shared learning from incidents. During this inspection, we found that managers investigated incidents and although efforts were made to promote incident learning, staff were not aware of any trends or themes in recent incidents. We were therefore not fully assured that there was any wider learning from incidents across all staff groups.
- As identified at the time of our last inspection, there were no formal morbidity and mortality meetings. Learning from any clinical case presentations was not shared with the wider directorate, or fed back to the board through any identifiable governance structure.
- The service did not controlled infection risk well. There was increased risk of cross infection, as the ITU environment was not compliant with recommended building (HBN04-02) standards for critical care units and National Institute for Health and Care Excellence (NICE) Quality Standards for infection control. The unit was unable to provide optimal care for patients requiring isolation facilities, such as positive and negative air pressure management. Since the time of our last inspection, the unit had completed the first phase of installation of a new ventilation plant, but this was not fully compliant with heating and ventilation for health sector building (HTM 03-01) standards. We found inconsistencies in hand hygiene practice amongst staff, in particular during ward rounds. There was dust on some equipment and high surfaces. This remained an area of concern from the time of the last inspection.
- The service had suitable equipment and looked after them well. However, we found inconsistencies in the daily checks of the difficult airway/ intubation trolley located in the unit. Nursing staff equipment competencies for some key pieces of equipment had not been rechecked since 2015 and were now overdue.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time. There were now effective documented systems in place for fridge temperature checks where medication was stored. This was an area of concern at the time of the last inspection. However, in the ITU, oxygen was not prescribed on the patient prescription chart as per the trust policy on the prescribing and administration of oxygen in adults.
- There were not enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. The nursing vacancy rate was high at 16%. Staff informed us that due to increased bed pressures recently, there had been many occasions when the supernumerary nurse would cover the short staffed or unfilled shifts. As identified at the last inspection, there was still no 24-hour cover provided by the critical care outreach team (CCOT).

However:

Critical care

- The service used safety monitoring results well. The unit now monitored incidents of falls, pressure ulcers, venous thromboembolism (VTE), central venous catheter infections and catheter associated urinary tract infections (UTIs). This information was displayed in both the staff room and on noticeboards within the unit. This had improved since the last inspection.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. There was a clear and effective process to ensure that potential safeguarding concerns were escalated.
- The unit had made progress with regard to consultant cover and now had a separate on-call rota. Consultants did not have additional responsibilities within the hospital while responsible for the critical care unit.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- The service monitored the effectiveness of care and treatment and used the findings to improve them. Since the last inspection, the unit had made improvement and was now contributing data to the Intensive Care National Audit and Research Centre (ICNARC). This meant patient outcomes were benchmarked against similar units nationally. The data submitted to ICNARC (April 2016 to March 2017) showed that the unit was within the expected range for most patient outcome measures.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences. There were processes to ensure pain relief was effective.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. There were high appraisal rates across the unit for nursing and support staff. The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units recommends 50% of critical care nurses should be in possession of a post-registration award in critical care nursing. The unit met this, with 69% of staff currently holding this qualification.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However:

- The unit did not use any sepsis screening tool and there was no separate policy for sepsis management in place. Although the outreach team told us that sepsis was part of the deteriorating patient policy. All junior staff we spoke with were not aware where to find information on sepsis management and if there was trust lead for sepsis.

Critical care

- The unit was not meeting the Core Standards for Intensive Care Units recommendation of having a practice nurse educator, who dedicated two-thirds of their time to this role. This was an area of concern at the last inspection and we found no improvement in regards to this provision.

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Observations of care showed staff maintained patients' privacy and dignity and patients and their families were involved in their care.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients and their relatives were kept informed of ongoing plans and treatment. They told us that they felt involved in the decision making process and were given clear information about their treatment.
- Staff provided emotional support to patients to minimise their distress.

However:

- Call bells were not within easy reach of patients.

Is the service responsive?

Requires improvement  

Our rating of responsive stayed the same. We rated it as requires improvement because:

The trust did not plan and provided services in a way that met the needs of local people. As identified at the time of the last inspection, the unit did not meet the requirement for modern critical care facilities as recommended by the Care Standards for Intensive Care Units. The unit had made no progress in relation to the facilities for patients and relatives since the time of the previous inspection.

There was only one patient toilet in the unit and no bath or shower facilities. Senior staff were aware of the challenges. They informed us that improvements were limited by the existing building and unless the unit was moved to a different location, there was no other option to expand.

Capacity and flow was one of the key areas of concerns for the unit. According to ICNARC data covering April 2016 to March 2017, delayed discharges took up a higher percentage of bed days compared to other similar units.

The service did not take account of patients' individual needs. The critical care outreach team followed up on patients discharged from the unit onto wards. However, the unit did not provide any ITU follow-up clinics once the patients were discharged from the hospital. There was inconsistency in terms of information about the visiting hours for relatives.

Staff have not received any specific training in identifying the needs of patients or relatives with learning disability. There was no learning disability lead for the trust but had a service level agreement with another trust for a learning disability specialist nurse to provide staff with learning disability advice. None of the staff we spoke with were aware of this

However:

- Patients had access to a range of foods including: soft options, vegetarian, gluten free, healthy heart options, halal meat and kosher food. There was written information available on the unit for patients and their relatives. Translation services were available via telephone or face-to-face.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. Relatives we spoke with were aware they could raise any issues with staff on the ward or seek assistance from patient advice and liaison service (PALS) if needed. There were information leaflets available for patients detailing how to access PALS.

Is the service well-led?

Requires improvement 

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Staff told us that divisional and executive team were not visible and rarely visited the unit. The staff also told us that there was little support for the critical care unit within the trust. They felt isolated and disjointed from the division and not part of the "bigger picture" within the trust. The majority of staff we spoke with were not aware of how their work contributed to the wider vision of the trust. There was a lack of any consensus regarding a cohesive future direction of the service.
- There was no effective governance structure. Not all the junior staff we spoke were aware of the departmental governance arrangements and how these fed into the overall divisional governance structure.
- Not all risks identified by us during the inspection were reflected on the risk register. For example, the lack of formal governance structure within the unit, the lack of morbidity and mortality meetings and the lack of mandatory sepsis training for staff were not included. In addition to this, many risks identified at the last inspection were still outstanding.
- Staff struggled to locate clinical guidelines quickly as the trust intranet search engine was not user friendly.
- Although senior staff had aspirations about the future of the service, there was no formal strategy being cohesively driven forward or promoted. The future direction of the service remained unclear.
- Since the time of the last inspection, there had been limited improvement in the facilities on the unit for relatives and visitors.
- Although the risks associated with the physical environment had been added to the trust risk register following our previous inspection, improvements had been limited. There were few plans to upgrade or improve the unit in the near future.

However:

- At a local level, there was clear leadership for both medical and nursing staff. The lead consultant and unit manager worked closely together. They were both visible in the department and junior clinical staff described them as approachable and supportive.
- We saw collaborative working between clinicians. Junior doctors and nurses felt supported, with regular supervision. We saw that the medical team worked well together, with consultants being available for junior doctors to discuss patients and to give advice where needed. Staff nurses told us that the culture in the department was one of coherence and mutual support.

Critical care

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Maternity

Good

Key facts and figures

The Hillingdon Hospital maternity services deliver care for approximately 5,000 women per year following the earlier than anticipated transition of services from Ealing as part of the "Shaping a Healthier Future", (SaHF) model of care in North West London. In 2013 there had been 4,076 births, representing a significant increase in the birth rate. From October 2016 to September 2017 there were 4,520 deliveries at the trust.

The trust provides a community midwifery service for women living within the London boroughs of Ealing and Hillingdon. The community midwives undertake the majority of antenatal and postnatal care. Antenatal and postnatal clinics are held at Hillingdon Hospital, Mount Vernon Hospital, The Ealing Hub and in children's centres. This service includes specialist clinics which covered diabetes, raised BMI, perinatal mental health, screening for blood disorders, vaginal birth after caesarean section (VBAC), fetal abnormality screening and safeguarding concerns.

The maternity unit is located within the hospital building. It has an 11 bedded delivery suite with two theatres, two recovery spaces and maternity triage. The delivery suite has a dedicated room with a birthing pool facility. There is also a four bedded midwifery led unit, for women on the midwifery led pathway (MLP). The antenatal ward has 13 beds, including a four bay day assessment unit. There are 24 postnatal beds, split between level 1 and level 3. The postnatal ward has a six bed transitional care unit which is staffed by neonatal nurses with support from a midwife and midwife support worker (MSW).

The hospital has a level 2 neonatal unit designed and equipped for babies needing extra medical and nursing care. This unit has five intensive, three high dependency and 12 special care cots.

During our inspection, we spoke with about 36 members of staff including midwives, maternity support workers, domestic staff, sonographers, consultants, trainee doctors, domestic staff and facilities and estates staff. We interviewed the head of midwifery after the inspection as she was away at the time of our visit. We spoke to 16 women who used maternity services and eight of their partners. We observed how staff were caring for patients and looked at the quality of the environment. We reviewed 26 sets of medical records and observed a multidisciplinary team (MDT) handover and observed a clinic at a children's centre. We reviewed a variety of hospital data including meeting minutes, policies and performance data.

Summary of this service

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated the service as good because:

- The trust had taken note of all concerns raised at the previous inspection and made improvements in the areas of staffing, cleanliness, reconfiguring the triage and day assessment area, and defects in security and theatre ventilation had been rectified.
- The service had responded effectively to accommodate the locally agreed increase in births at the hospital which had taken place earlier than anticipated and the transition had been smooth.
- Risks to women were well-identified and well-managed in antenatal care, intrapartum and postnatal care.
- There were clearly defined and embedded systems and processes in place to keep people safe and safeguard them from abuse. Safeguarding was well managed and the new midwife service to women with social or mental health concerns had been strengthened to provide 24 hour telephone support for vulnerable women.

Maternity

- There was an open culture of incident reporting and a willingness to learn from incidents.
- The governance arrangements were systematic and well understood. There was a responsive audit programme clearly focused on improving outcomes for women and prompt response to findings.
- Staff engagement was strong and midwives and doctors worked closely and without hierarchy. All staff shared the same aims and vision for the service.
- Women we spoke with were happy with their care and praised staff for being welcoming and supportive.
- The service's engagement with the local maternity network was proactive in coordinating care, and they were involved as early adopters of improved methods of care in many areas.
- Trainee doctors were very positive about the support and teaching they received from senior clinicians, and obstetric training posts at the trust were sought after.
- The service met expected patient outcomes for women in most areas, and in some areas exceeded these, for example in having a low rate of planned caesarean sections. The service assessed themselves against external standards in published reports and sought continuous improvement.

Is the service safe?

Good

We rated safe as good because:

- The safety concerns from the previous inspection related to staffing, cleanliness, medicine storage, lack of high dependency beds, theatre ventilation and security. These had all been resolved. More midwives had been appointed, who worked flexibly across the service and the caseloads of community midwives had been reduced. Women were now cared for in a clean environment, and medicines were now stored and managed appropriately. The service had a dedicated high dependency area (HDU) on the delivery suite. Access to the maternity area was secure with cameras on external doors, alarms on fire doors and buzzer access to wards.
- Ventilation quality in theatres had been rectified through appropriate remedial work and there was a six monthly validation check.
- There were comprehensive systems and training to protect people from abuse. Staff were knowledgeable about safeguarding and used well-developed care pathways for women identified as being 'at risk' because of medical, mental health conditions or vulnerability. Support for women with social or mental health problems had recently been strengthened.
- The service assessed risks to woman and babies proactively at different stages of the maternity pathway.
- The department strongly supported training and development of midwives and doctors, through site based practice development and dedicated teaching time.
- The service had systematic and established systems in place for reporting, investigating and acting on incidents and serious adverse events. There was an open culture of reporting, and learning was shared with staff to make improvements. There were also opportunities to learn from external safety events.
- The service had systematic and established systems in place for reporting, investigating and acting on incidents and serious adverse events. We saw evidence that learning was shared with staff to promote improvements.

However:

Maternity

- We observed inconsistent adherence to good hand hygiene practice on the postnatal ward. We saw some examples of midwives and doctors not carrying out hand hygiene appropriately before and after care.
- The physical capacity of the delivery suite sometimes delayed women moving to the delivery suite after induction of labour.

Is the service effective?

Good

We rated effective as good because:

- Senior managers monitored patient outcomes continuously through the use of a rolling maternity dashboard and national and local audits, thereby having a clear assurance of quality against identified goals.
- The service provided care and treatment based on national professional standards, guidelines and evidence- based practices.
- The maternity audit schedule was comprehensive and audit plans included audit of risks rated as high on the risk register.
- The rate of midwifery led births was 17% and an enhanced recovery programme was available to women having planned caesarean sections.
- The breastfeeding initiation rate was above the national average. The service was aiming for accreditation at UNICEF Baby Friendly Initiative Level 2 in September 2018.
- A multidisciplinary approach ensured women with pre-existing medical conditions, including mental health issues, had an integrated approach to antenatal and postnatal care.
- Staff were supported to maintain and further develop their professional skills and experience by an active practice development team. Staff we spoke with had taken part in simulation skills training and drills to support their response to emergencies, and had training on perinatal mental health to improve patient outcomes for mothers with mental health needs.
- A team of nine professional midwifery advocates provided supervision to staff independent of line management, and a member of the team was available to support staff 24 hours a day.
- Outcomes for women were good in comparison with other units in the region and mainly met national goals, although they did not exceed these.

Is the service caring?

Good

We rated caring as good because:

- Staff treated patients and their families with compassion, patience and respect.
- We observed compassionate care being delivered to women. Staff protected the dignity and privacy of women in all areas of the service.

Maternity

- All women we spoke with on the postnatal ward spoke positively about their experiences of care. Partners were made to feel welcome and involved in their partner's pregnancy, labour and birth.
- The Friends and Family Test is a measure of patient satisfaction. Findings showed women and their families had a good experience in the maternity services and women and their partners told us they would recommend the service to others.
- Women had continuity of care before and after birth from a local team of community midwives which enabled them to establish trusting relationships.
- Specialist staff offered emotional support to women and those close to them. The support provided includes the sensitive management of loss for women suffering miscarriages or stillbirth.

Is the service responsive?

Good

We rated responsive as good because:

- Antenatal clinics were available at many locations in the community, which minimised women's need to travel to the hospital. At the last inspection continuity of antenatal care was not always provided. At this inspection a number of ways of improving continuity were being trialled to improve continuity. Women we spoke to did not express concerns about continuity of care.
- At the last inspection there had been no dedicated room for bereaved mothers. There was now an allocated room, although this was sometimes used by other women for delivery when the unit was busy. There was a plan to build a separate room and some funding had been raised from a charity.
- Women could register for antenatal care online and refer themselves for some concerns such as reduced fetal movement.
- There were arrangements in place to support people with particular needs with good access to specialist midwives.
- We saw a range of information on display in community and hospital clinics including aspects of maternity care as well as on sexual health, safeguarding and how to raise a concern. Most information was available in other languages to meet the diverse needs of families in the area,

However:

- Women had some concerns about their experience of triage and the antenatal ward. Some felt they experienced too long a delay in moving to the delivery suite, and that the antenatal ward was not a private enough environment in early labour.
- There was only one birthing pool which meant that most women did not have the option of water immersion for pain relief or water birth. Women on the postnatal ward said they would have liked to access to a fridge and microwave.

Is the service well-led?

Outstanding

We rated it as outstanding because:

Maternity

- Managers had responded with energy and commitment to the earlier than anticipated transition of maternity services from Ealing as part of the "Shaping a Healthier Future", (SaHF) model of care in North West London. They had worked very effectively to manage risks and plan for contingencies to accommodate the number of women needing maternity services at Hillingdon. This change had involved recruiting 60 more staff.
- Staff at all levels were able to explain the maternity service vision for the future, and shared the objectives of providing safe local maternity care for local women, and increasing the proportion of women having normal births. The vision was fully aligned with plans for the wider health economy, and staff valued and demonstrated commitment to system-wide collaboration.
- Governance and arrangements for assessing and monitoring the quality of the service were focused on achieving a high quality, person-centred experience for all women. Managers had a clear grip on data needs and quality, and managing local risks. They had resolved all areas of concern at the previous inspection and brought in other improvements as part of the expansion of the service.
- An up to date risk register was used to identify risks, provide action plans and update guidelines and procedures in the department. Risks were identified and mitigations put in place with systematic monitoring through the maternity governance group.
- We saw evidence of effective forward planning on the delivery suite so staff were aware of expected deliveries and women's known needs for example elective caesarean sections, or any specific risks. This ensured as far as possible that a delivery bed was available and staffing was appropriate to cover these as well as the inevitable unscheduled events. We saw midwives and doctors worked as an effective, inclusive team without hierarchy.
- Systematic governance processes provided sound assurance on performance, safety and risk. Data and information was shared in an open and honest way with staff and stakeholders. Risks and issues were managed effectively within the constraints of finance, and we saw evidence of prompt action being taken where incidents or audits revealed a need for change.
- The service audited itself against a range of processes and outcomes, as well as reviewing their practice and performance against best practice and action plans from national reports such as Each Baby Counts and Saving Babies Lives'. The service performed very well against these comparisons.
- Leaders had successfully developed a culture within the service that was open, collaborative, and receptive to new ideas and change. Staff throughout the service were involved as early adopters of new methods of care. Staff at all levels spoke of feeling ownership of the services they provided to women and families, and staff turnover was low. Although this was a medium sized maternity unit, it had the friendly and cohesive feel of a smaller unit. A closed Facebook page was used for sharing information in addition to more formal channels. Staff were proud to work in a maternity service that was well-respected by women and families.
- Staff told us the head of midwifery and senior obstetricians were visible and enthusiastic about providing excellent care for women. Leadership was shared effectively so that a wide range of staff were engaged in leading and managing the maternity service at different levels, ensuring strong leadership development within the service.
- At the previous inspection staff had not felt managers listened to their concerns, but at this inspection staff felt well supported by all staff in the unit, both by managers and by their peers. They felt they were involved in developing ideas to improve the service. Examples were the strong professional midwife advocate arrangements and strengthened support for women with perinatal mental health issues which took a holistic approach to the needs of mother and child and could offer support for up to a year.
- There was a strong focus on continuous learning and improvement at all levels of the organisation and the maternity unit was in involved in regional and national pilots focused on improving care. Staff had training on situational awareness and human factors training was being developed to improve safety and performance.

Maternity

- Friends and family test response rates were higher than national rates and outcomes were better than the national average. A new maternity voices partnership had been set up and staff were actively seeking engagement from a wider range of women to make it more inclusive of the local population. The provision of information in other languages was a means to engage a wider range of users.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Services for children and young people

Good ↑

Key facts and figures

The paediatric department at Hillingdon Hospital is part of the Women's and Children's Division of the Hillingdon Hospitals NHS Foundation Trust. The hospital provides a wide range of services to children and young people mainly from West London.

In the 12 months prior to our inspection there were 5,533 inpatient spells of which 90% (4,982) were emergency, 9% (514) were day case spells and 1% (37) were elective.

We visited the paediatric department for an announced inspection over three days between 6,7 and 8 March 2018. We spoke with staff including consultants, nurses, allied health professionals, clerical and admin staff and managers of the service. We also spoke with patients and their families who used the service. We observed care and treatment and looked at a sample of 10 patient records. We visited all paediatric areas in the hospital and some adult areas where children were seen such as imaging and outpatients.

Summary of this service

Our rating of this service improved. We rated it as good because:

- There was an open and constructive culture of sharing and learning from incidents.
- Safeguarding knowledge and processes had improved. Staff understood their responsibilities and how to keep patients safe.
- Medicines were stored and managed appropriately; patients received the correct doses at the right times.
- The effectiveness of care and treatment was monitored and improvements were made as a result.
- Nutrition and hydration needs were met as a result of effective monitoring.
- Patients' pain was managed and monitored well.
- There was a multidisciplinary approach to patient care and staff worked well together to deliver an effective service.
- Staff cared for patients with compassion and ensured that dignity and privacy were respected.
- There was good emotional support for patients and their families and carers.
- Patients and those close to them were supported to understand their care and treatment and were involved in making decisions.
- The department delivered a broad range of services including speciality and one-stop clinics.
- There was timely access to services and good flow through the department.
- There was a positive, 'can do' culture in the department and staff were proud to work there.
- There had been an improvement since the previous report in staff feeling listened to and supported by their managers.
- There were processes for engaging staff in news and developments in the department including newsletters and meetings.

However:

- The department had not implemented a seven day service.
- There were limited examples of the department supporting patients to manage their own health.
- Staff did not receive formal training provision for learning disabilities and the service relied on support from external partners or the trust's learning disability link nurse.
- Some areas where children were seen in adult outpatients were not child friendly.
- Parents reported delays in seeing the dietitian.
- There was limited engagement with patients and those close to them to gather their input in improving the service.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- There was a good culture in the service of learning from incidents. Staff were encouraged to report incidents and they received timely feedback. When things went wrong, staff were open and honest and gave patients suitable support.
- In the previous report we found that the trust needed to make sure staff were appropriately trained in safeguarding and understood their responsibilities I relation to safeguarding processes. We found that this had improved and staff had a good awareness of safeguarding responsibilities and knew how to make referrals. There was good multi-agency practice in safeguarding children.
- Equipment was stored, clean and checked appropriately and staff managed the risk of infection.
- We found that documentation of paediatric early warning scores had improved since the last inspection. Staff responded appropriately to triggers and prompts indicating deterioration.
- Medicines were appropriately stored and managed. There were safe processes in place to ensure patients received the correct medications.
- There were high mandatory training completion rates. Staff felt that mandatory training was comprehensive and effective.
- Records were legible, up to date and available for all staff providing care.

However:

- We were told that the extra nursing staff required to run five high dependency unit beds on the ward occasionally meant there were not enough staff for the ward to be safe when there was high patient acuity.

Is the service effective?

Good →←

Our rating of effective stayed the same. We rated it as good because:

- The effectiveness of care and treatment was monitored and findings were used to make improvements to the service.

- There were processes to ensure pain relief was effective and that nutrition and hydration needs were met.
- Staff were competent for their roles and the hospital ensured that staff could improve their competency. There were high appraisal rates across paediatrics.
- Staff understood their roles and responsibilities under the Mental Capacity Act 2005 and knew how to support patients experience mental ill health.
- Staff of different disciplines worked together to deliver effective patient care. Doctors, nurses and other healthcare professionals supported each other well.

However:

- The department had not implemented seven day services. The majority of services ran from 8:30 to 6pm Monday to Friday.
- There were limited examples of the service supported patients to manage their own health effectively.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients and their families through the Friends and Family Test and during the inspection confirmed that staff treated them with kindness and sensitivity.
- There was effective emotional support for patients and their relatives available from the department and staff understood and responded to patients' wellbeing.
- Clinicians made an effort to promote patient understanding and involvement in decisions about their care and treatment.

Is the service responsive?

Good 

Our rating of responsive improved. We rated it as good because:

- Staff knowledge of translation and advocacy services to support patients with English as an additional language had improved. Staff felt confident about arranging and accessing in-person and remote translation services including British sign language services effectively.
- The Paediatric Assessment Unit (PAU) had improved the flow of patients from A&E to the ward and ensured that patients who did not need to be admitted could be monitored on the PAU.
- The hospital delivered a broad range of services for children and young people, including a number of specialist paediatric clinics such as one-stop allergy clinics, diabetes and respiratory services.
- The service had developed a number of integrated community clinics including asthma and diabetes clinics in schools which helped to reduce admission to hospital.
- There was timely access to children and young people's services and there was a good overall compliance for referral to treatment times.

- The 24/7 telephone and email advice line GPs used to speak with a consultant paediatrician was working effectively and helped reduce admissions as well as provide a rapid access service so that a child could be referred to the paediatric assessment unit.

However:

- Staff did not receive formal training provision for learning disabilities and the service relied on support from external partners or the trust's learning disability link nurse.
- Some areas where children were seen in adult outpatients were not child friendly.
- Parents reported delays in seeing the dietitian.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good because:

- There was a positive, collaborative and child focussed culture in the department which had improved since the previous report. Staff worked well together and supported each other effectively. Staff told us they felt proud to work at the trust and spoke highly of their colleagues and managers.
- There had been an improvement from the previous report in staff reporting feeling supported and listened to by their managers.
- There was effective leadership and clear governance processes for making decisions. Staff we spoke with told us that leaders were approachable and they could have an input to the running of the department. There was an effective and established leadership team and good representation of services for children and young people across the trust.
- Staff understood the trust vision and values and could apply them to their work in the paediatric department.
- There were processes for engaging staff including regular meetings and newsletters.
- The unit kept a comprehensive risk register which was reflective of what we found on inspection. There were effective processes for identifying, monitoring and mitigating risks.

However:

- There was no formalised strategy for the paediatric department. Managers were able to tell us their plans for the future but these were not recorded or consistent.
- Staff we able to give limited examples of engagement with patients and families in designing and improving the service. Patients and their families were not given the opportunity to contribute to plans for the future of the service.
- There were limited examples of innovative practice in the paediatric department.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

End of life care

Good ↑

Key facts and figures

The trust provides end of life care (EOLC) at The Hillingdon Hospital (THH).

EOLC encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust and also in the community. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

Palliative care is a multidisciplinary approach to specialised medical care for people with serious illnesses, both cancer and other illnesses. It focuses on providing patients with relief from the symptoms, pain, physical stress and mental stress of a serious illness. The goal is to improve quality of life for both the patient and the family.

The trust has a multidisciplinary specialist palliative care team (SPCT) that consists of three palliative consultants and four WTE clinical nurse specialists (CNSs). The trust had an integrated approach to working with patients at the end of their life, therefore there were no allocated beds or wards for end of life care patients. Instead, patients at the end of life were cared for on medical wards. The SPCT also supports ward staff to deliver care to patients at the end of their life.

The SPCT delivers face-to-face CNS and consultant cover in the trust Monday to Friday, 9am to 5pm. The service does not operate on the weekends. Out of hours, advice is provided by the local hospice via telephone.

From October 2016 to September 2017 the trust had 782 deaths.

The trust is part of the London EOLC clinical network and is also a member of the Royal Marsden Partners Cancer Vanguard. Local partners include the Mount Vernon Cancer Centre, the Michael Sobell House Specialist Palliative Care Centre, and the Harlington Hospice.

A bereavement team provides support to relatives from Monday to Friday, 9am to 12pm. There is a chaplaincy service available to patients, relatives and staff, seven days a week. THH has its own Macmillan Information Centre on site.

We previously inspected the service in October 2014. Concerns identified during this inspection included a lack of side rooms for private conversations to be held, no end of life care strategy and limited governance systems in place. Also, the completion of 'do not attempt cardio pulmonary resuscitation' (DNACPR) forms was variable and the documentation of mental capacity assessments was inconsistent.

We completed an announced inspection of the end of life care service on 6, 7 and 8 March 2018. We visited nine wards, including medical and surgical wards, the emergency department, the acute medical unit (AMU) and the critical care ward. We visited the mortuary, the bereavement team and the multi-faith room. We spoke with three patients and four relatives. We spoke with all members of the SPCT team and over 20 members of the wider staff including medical and nursing staff, portering service staff and mortuary and chaplaincy staff. We reviewed 10 patient care records, 15 DNACPR forms and six medication charts.

Summary of this service

Our rating of this service improved. We rated it as good because:

- We rated safe, effective, caring, responsive and well-led as good.

End of life care

- The ratings of safe, effective, responsive and well-led improved since the last inspection. The rating for caring remained the same.
- Since our last inspection there had been a focus on the trust wide understanding and development of end of life acre. There was now a strategy and governance programme in end of life care with a clear structure of leadership and accountability.
- Appropriate measures were in place to keep patients safe from avoidable harm. Record keeping had improved.
- There were specialised end of life care advanced care plans in place and risk assessments had been adapted for patients at the end of their lives.
- Team working was strong and the development of staff within the specialist palliative care team had strengthened governance structures. There was a non-executive director in place that sat on the board and had end of life care oversight.
- Patients were provided with compassionate and person-centred care, which took account of their individual differences and needs. There was multi-disciplinary input to ensure that patients received a holistic and individualised care plan.
- The specialist palliative care team had developed end of end training within the trust and worked well with external agencies in order to coordinate care for each patient.

However:

- There was not always evidence that the appropriate mental capacity assessments had been carried out where this was noted in the patients DNACPR form.
- There was no end of life champion on each ward and the SPCT team did not take oversight for the training of staff in syringe pumps.
- The bereavement service had limited opening hours and inappropriate waiting areas for bereaved family members.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at right time in the right dose as per national guidelines.
- At the time of our last inspection we found the completion of 'do not attempt cardio pulmonary resuscitation' (DNACPRs) was variable and the documentation of mental capacity assessments was inconsistent. At the time of this inspection, the completion of DNACPRs had improved greatly. Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.

End of life care

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- At our last inspection, end of life care was not included in the trust mandatory training programme. The service had since then made strides to ensure that all new staff received an introduction to end of life care. The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. The specialist palliative care team was run effectively by the right specialities.
- The service planned for emergencies and staff understood their roles if one should happen.

However:

- The service did not use safety monitoring results well. The service was not effectively carrying out audits on end of life patients falls, pressure ulcers, medicines reconciliation or incidents relating specifically to end of life patients. This was expected to be picked up in the medicines or surgical directorate.

Is the service effective?

Good  

Our rating of effective improved. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Since our last inspection the service had implemented end of life guidance to replace the Liverpool Care Pathway. The service monitored the effectiveness of care and treatment and used the findings to improve them. The mortuary staff carried out many different audits and measured outcomes frequently.
- At the time of our last inspection, the end of life training schedule had been put on hold and not all staff had been trained in end of life care. At the time of this inspection. 78 members of staff across the two showcase wards had been trained in end of life care. The SPCT also provided ad-hoc ward based training and were due to launch the end of life care induction for new doctors and nurses. The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Multi-disciplinary working was very effective and staff worked together across both specialities and organisations to ensure that patients had effective end of life care.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

However:

- As at the time of our last inspection we found that mental capacity assessments were not always carried out.
- There were no end of life champions on the wards.

End of life care

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients and relatives confirmed that staff treated them well and with kindness. Palliative patients had access to clinical psychology input and there was no waiting list for this service.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress. Patients had access to a multi-faith chapel, a chaplain and other faiths had the same access.

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people. The service made efforts to plan services and clinics in a way that met the needs of palliative patients and their family members.
- At the time of our last inspection we found that the SPCT were able to arrange rapid discharge for people who wished to die in a different location. This was the case at the time of our most recent inspection with the majority of patients dying in their preferred place of death. People could access the service when they needed it. When referred into the service, the majority (90%) of patients were seen with 24 hours and staff often worked outside of their contracted hours in order to see all patients in this time frame.
- The service took account of patients' individual needs. This included disadvantaged patients.

However:

- The bereavement service had limited opening hours and inappropriate waiting areas for bereaved family members.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good because:

- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Since our last inspection the service had improved its leadership structure and the triumvirate that lead the specialist palliative care team worked together effectively.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. Since our last inspection, the service had developed a strategy that was embedded in the work of the team and understood by the wider staff.

End of life care

- Managers across the service promoted a positive culture that support and valued staff, creating a sense of common purpose based on shared values.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborate with partner organisations effectively.
- The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Outpatients

Requires improvement

Key facts and figures

Outpatient services at the trust were spread over two main sites at Hillingdon Hospital and Mount Vernon Hospital as well as some community locations which included GP Practices, Health Centres and Schools, for the purposes of this inspection we focussed on outpatient services based at Hillingdon Hospital. The trust hosted different speciality clinics including "one stop clinics" in Breast Care, Cardiology, Transient Ischaemia Attack (TIA) clinic and Care of the Elderly clinics. The trust had 381,756 first and follow-up outpatient appointments from October 2016 to September 2017.

We inspected the outpatient services on the 6, 7 and 8 March 2018. We visited all outpatient areas including the main outpatient department, fracture clinic, rheumatology, women's centre, phlebotomy, Alderbourne unit, ophthalmology and all associated clinics that were running during the inspection. We also visited the Christian chapel, Muslim prayer room, Macmillan cancer centre and the outpatient pharmacy. We spoke to 15 patients and with over 25 members of staff across medical, nursing, healthcare assistant and allied health professional staff. We reviewed 10 patient records.

Summary of this service

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- We rated safe and well-led as requires improvement, and responsive and caring as good. We do not rate effective for this core service.
- The rating for responsive improved since the last inspection; the rating for safe went down and the rating for each of the other key questions remained the same.
- We were not assured that the laser service met the Medicines and Healthcare Products Regulatory Agency safety standards
- The laser service did not have a laser protection advisor in place since the start of the laser service in 2012, although the trust was making suitable arrangements at the time of the inspection there still was no one officially in post.
- We were not assured the department had adequate governance procedures for the laser service as set by the Medicines and Healthcare Products Regulatory Agency safety standards. Risks associated with laser practice were not present on any trust risk register.
- Staff did not always maintain appropriate records of patients' care and treatment. Records were not always clear, up-to-date and available to all staff providing care.
- The service did not have suitable premises and there was a large backlog of estates maintenance.
- The service provided mandatory training in key skills to all staff.
- The service did not actively monitor the effectiveness of care and treatment and use this information to improve the service.
- The department had managers with the right skills to run the service; however senior nurses felt that their managerial duties were at times excessive of their role.

Outpatients

- The service had a vision for what it wanted to achieve, however we were not assured it had workable plans to turn it into action.
- The service had limited engagement with patients and staff to plan and manage appropriate services.
- The service had systems for identifying risks and planning to eliminate them, however the services active risks were of an excessive age.

However:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so; however some compliance with some training failed to meet trust targets.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment.
- The trust planned and provided services in a way that met the needs of local people.
- People could access the service when they needed it. Waiting times from referral to treatment were in line with good practice.
- The service took account of patients' individual needs.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Outpatients

Is the service safe?

Requires improvement

We rated it as requires improvement because:

- We were not assured that the laser service met the Medicines and Healthcare Products Regulatory Agency safety standards.
- The laser service did not have a laser protection advisor in place since the start of the laser service in 2012, although the trust was making suitable arrangements at the time of the inspection there still was no one officially in post.
- Staff did not always maintain appropriate records of patients' care and treatment. Records were not always clear, up-to-date and available to all staff providing care.
- The service did not have suitable premises and there was a large backlog of estates maintenance.

However:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so; however some compliance with some training failed to meet trust targets.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Is the service effective?

We do not rate effective:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- The service ensured patients had access to enough food and drink to meet their needs. The service made adjustments for patients' religious, cultural and other preferences.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However:

Outpatients

- The service did not actively monitor the effectiveness of care and treatment and use this information to improve the service.

Is the service caring?

Good

We rated caring as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress.

Is the service responsive?

Good

We rated responsive as good because:

- The trust planned and provided services in a way that met the needs of local people.
- People could access the service when they needed it. Waiting times from referral to treatment were in line with good practice and had improved since our previous inspection. All but one speciality was performing better than the national standard.
- The service took account of patients' individual needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Is the service well-led?

Requires improvement

We rated well-led as requires improvement because:

- The department had managers with the right skills to run the service; however senior nurses felt that their managerial duties were at times excessive of their role.
- The service had a vision for what it wanted to achieve, however we were not assured it had workable plans to turn it into action.
- We were not assured the department had adequate governance procedures for the laser service as set by the Medicines and Healthcare Products Regulatory Agency safety standards. Risks associated with laser practice were not present on any trust risk register.
- The service had limited engagement with patients and staff to plan and manage appropriate services.

- The service had systems for identifying risks and planning to eliminate them, however the services active risks were of an excessive age.

However:

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Our inspection team

The team was led by Nicola Wise, CQC head of hospital inspection. Robert Throw CQC inspection manager was the lead inspection manager for this inspection. An executive reviewer, Anna Hills, deputy chief executive of James Paget University Hospitals NHS Foundation Trust, supported our inspection of well-led for the trust overall.

The team included a CQC inspection manager, inspectors, specialist advisers and experts by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are medical, clinical and managerial experts in their field who we do not employ directly. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.

EXTERNAL SERVICES SELECT COMMITTEE - WORK PROGRAMME

Committee name	External Services Select Committee
Officer reporting	Nikki O'Halloran, Chief Executive's Office
Papers with report	Appendix A – Work Programme Appendix B – Scoping Report: GP Pressures
Ward	n/a

HEADLINES

To enable the Committee to track the progress of its work and forward plan.

RECOMMENDATIONS:

That the External Services Select Committee:

1. **considers the Work Programme at Appendix A and agrees any amendments;**
2. **identifies topics for the Crime and Disorder meeting on 12 February 2019;**
3. **identifies issues to be considered at the meeting on 13 March 2019;**
4. **agrees the membership of the Select Panel; and**
5. **agrees the Select Panel scoping report at Appendix B.**

SUPPORTING INFORMATION

1. The Committee's meetings tend to start at either 5pm or 6pm and the witnesses attending each of the meetings are generally representatives from external organisations, some of whom travel from outside of the Borough. The meeting dates for this municipal year are as follows:

Meetings	Room
Wednesday 13 June 2018, 6pm	CR6
Tuesday 10 July 2018, 6pm	CR6
Thursday 6 September 2018, 6pm	CR6
Wednesday 10 October 2018, 6pm	CR5
Tuesday 30 October 2018, 6pm	CR3/CR3a
Tuesday 13 November 2018, 6pm	CR6
Tuesday 15 January 2019, 6pm	CR6
Tuesday 12 February 2019, 6pm	CR6
Wednesday 13 March 2019, 6pm	CR6
Wednesday 10 April 2019, 6pm	CR6

2. It has previously been agreed by Members that, whilst meetings will generally start at 6pm, consideration will be given to revising the start time of each meeting on an ad hoc basis should the need arise. Further details of the issues to be discussed at each meeting can be found at

Appendix A. Members should note that further consideration will need to be given to the content of the meeting in March 2019.

3. At its meeting on 6 September 2018, Members agreed to schedule an additional meeting to review the action taken in relation to the recent closure of Michael Sobell Hospice. This meeting has been scheduled for 6pm on Tuesday, 30 October 2018.

4. It should be noted that the Committee is required to meet with the local health trusts at least twice each year. It is also required to scrutinise the crime and disorder work of the Safer Hillingdon Partnership (SHP). To keep the crime and disorder meetings focussed, as well as receiving a general update on the performance of the SHP, specific topics are identified for each of the meetings and only the relevant SHP partners are invited to attend. Consideration will need to be given to the topics for the meeting that has been scheduled for 12 February 2019.

Reviews

5. As the meetings of the External Services Select Committee usually deal with a lot of business, the Committee is able to set up Select Panels to undertake in depth reviews on its behalf. These Panels are 'task and finish' and their membership can comprise any London Borough of Hillingdon Councillor, with the exception of Cabinet Members.

6. Although the External Services Select Committee had previously agreed to set up a Panel to undertake a review of cancer screening and diagnosis during this municipal year, it became apparent that significant improvements had been made to the service provision. As such, it was agreed at the meeting on 6 September 2018 that the Committee would undertake a single meeting review of the issue at its meeting on 15 January 2019.

7. It was also agreed by Members on 6 September 2018 that the Committee set up a Select Committee Panel to update the GP pressures work that had previously been undertaken by a Working Group in 2015/2016. An updated scoping report on this topic has been included at Appendix B.

8. Members are now asked to consider the scoping report and make revisions as necessary. In addition, Members need to agree the membership of the Panel and determine when the final report of the Select Panel should be brought back to the Committee before being considered by Cabinet.

BACKGROUND PAPERS

None.

APPENDIX A

EXTERNAL SERVICES SELECT COMMITTEE

WORK PROGRAMME

NB – all meetings start at 6pm in the Civic Centre unless otherwise indicated.

Shading indicates completed meetings

Meeting Date	Agenda Item
13 June 2018 ***Report Deadline**:* *3pm Friday 1 June 2018*	**The Role of Policy Overview and Select Committees**
10 July 2018 ***Report Deadline**:* *3pm Friday 29 June 2018*	**Health** Performance updates and updates on significant issues: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Royal Brompton & Harefield NHS Foundation Trust 3. Central & North West London NHS Foundation Trust 4. The London Ambulance Service NHS Trust 5. Public Health 6. Hillingdon Clinical Commissioning Group 7. Healthwatch Hillingdon 8. Local Medical Committee
6 September 2018 ***Report Deadline**:* *3pm Friday 23 August 2018*	**Crime & Disorder** To scrutinise the issue of crime and disorder in the Borough: 1. Metropolitan Police Service (MPS) – new policing arrangements, knife crime; closure of the child friendly policing facilities in Northwood. **Update on the implementation of recommendations from previous scrutiny reviews:** • Criminalisation of Looked After Children • Child Sexual Exploitation
10 October 2018 ***Report Deadline**:* *3pm Friday 28 September 2018*	**The Hillingdon Hospitals NHS Foundation Trust – CQC Inspection Report** **Major Review:** Consideration of scoping report.
30 October 2018 ***Report Deadline**:* *3pm Friday 19 October 2018*	**Hospice Provision in the North of the Borough** 1. Michael Sobell Hospice Charity 2. The Hillingdon Hospitals NHS Foundation Trust 3. East and North Herts NHS Foundation Trust 4. Hillingdon Clinical Commissioning Group 5. Healthwatch Hillingdon

Meeting Date	Agenda Item
13 November 2018 ***Report Deadline**:* *3pm Thursday 1 November 2018*	**Health** Performance updates and updates on significant issues: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Royal Brompton & Harefield NHS Foundation Trust 3. Central & North West London NHS Foundation Trust 4. The London Ambulance Service NHS Trust 5. Public Health 6. Hillingdon Clinical Commissioning Group 7. Healthwatch Hillingdon
15 January 2019 ***Report Deadline**:* *3pm Thursday 3 January 2019*	**Cancer Screening and Diagnostics – Single Meeting Review**
12 February 2019 ***Report Deadline**:* *3pm Thursday 31 January 2019*	**Crime & Disorder** To scrutinise the issue of crime and disorder in the Borough: 1. London Borough of Hillingdon 2. Metropolitan Police Service (MPS) 3. Safer Neighbourhoods Team (SNT) 4. London Fire Brigade 5. London Probation Area 6. British Transport Police 7. Hillingdon Clinical Commissioning Group (CCG) 8. Public Health
13 March 2019 ***Report Deadline**:* *3pm Thursday 28 February 2019*	
10 April 2019 ***Report Deadline**:* *3pm Thursday 28 March 2019*	**Health** Quality Account reports, performance updates and updates on significant issues: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Royal Brompton & Harefield NHS Foundation Trust 3. Central & North West London NHS Foundation Trust 4. The London Ambulance Service NHS Trust 5. Public Health 6. Hillingdon Clinical Commissioning Group 7. Healthwatch Hillingdon
June 2019 ***Report Deadline**: TBA*	**Update on the implementation of recommendations from previous scrutiny reviews:** • Hospital Discharges (SSH&PH POC) • Community Sentencing

Meeting Date	Agenda Item
July 2019 ***Report Deadline**: TBA*	**Health** Performance updates and updates on significant issues: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Royal Brompton & Harefield NHS Foundation Trust 3. Central & North West London NHS Foundation Trust 4. The London Ambulance Service NHS Trust 5. Public Health 6. Hillingdon Clinical Commissioning Group 7. Healthwatch Hillingdon
September 2019 ***Report Deadline**: TBA*	**Crime & Disorder** To scrutinise the issue of crime and disorder in the Borough: 1. London Borough of Hillingdon 2. Metropolitan Police Service (MPS) 3. Safer Neighbourhoods Team (SNT) 4. London Fire Brigade 5. London Probation Area 6. British Transport Police 7. Hillingdon Clinical Commissioning Group (CCG) 8. Public Health
October 2019 ***Report Deadline**: TBA*	
November 2019 ***Report Deadline**: TBA*	**Health** Performance updates and updates on significant issues: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Royal Brompton & Harefield NHS Foundation Trust 3. Central & North West London NHS Foundation Trust 4. The London Ambulance Service NHS Trust 5. Public Health 6. Hillingdon Clinical Commissioning Group 7. Healthwatch Hillingdon
January 2020 ***Report Deadline**: TBA*	
February 2020 ***Report Deadline**: TBA*	**Crime & Disorder** To scrutinise the issue of crime and disorder in the Borough: 1. London Borough of Hillingdon 2. Metropolitan Police Service (MPS) 3. Safer Neighbourhoods Team (SNT) 4. London Fire Brigade 5. London Probation Area 6. British Transport Police 7. Hillingdon Clinical Commissioning Group (CCG) 8. Public Health

Meeting Date	Agenda Item
March 2020 ***Report Deadline**: TBA*	
April 2020 ***Report Deadline**: TBA*	**Health** Quality Account reports, performance updates and updates on significant issues: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Royal Brompton & Harefield NHS Foundation Trust 3. Central & North West London NHS Foundation Trust 4. The London Ambulance Service NHS Trust 5. Public Health 6. Hillingdon Clinical Commissioning Group 7. Healthwatch Hillingdon
Possible future single meeting or major review topics and update reports	
• Telecommunications - plans in place by BT regarding advancements made in mobile technology • Mental health discharge • Post Offices • Collaborative working between THH and GPs in the community • Opportunities for local oversight of services provided in Hillingdon that had been commissioned from outside of the Borough • Transport provision within the Borough - Transport for London (TfL), Crossrail, bus route changes and Dial-a-Ride	

PROPOSED MAJOR REVIEW (PANEL)

Members of the Panel:

- Councillors TBA

Topic: GP Pressures

Meeting	Action	Purpose / Outcome
ESSC: 10 October 2018	Agree Scoping Report	Information and analysis
Panel: **1st Meeting -** TBA	Introductory Report / Witness Session 1	Evidence and enquiry
Panel: **2nd Meeting -** TBA	Witness Session 2	Evidence and enquiry
Panel: **3rd Meeting -** TBA	Witness Session 3	Evidence and enquiry
Panel: **4th Meeting -** TBA	Consider Draft Final Report	Proposals – agree recommendations and final draft report
ESSC: TBA	Consider Draft Final Report	Agree recommendations and final draft report
Cabinet: TBA *(Agenda published: TBA)*	Consider Final Report	Agree recommendations and final report

Additional stakeholder events, one-to-one meetings, site visits, etc, can also be set up to gather further evidence.

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HILLINGDON
LONDON

External Services Select Committee Review Scoping Report 2018/19

GP Pressures

Aim and background to review

Introduction

A review into GP pressures was originally initiated in 2015/16. Given that this topic continues to be of considerable importance and relevance today, the Committee has agreed to resume the review at this juncture. The proposed new review by an External Services Select Panel aims to consider the work undertaken by the previous Working Group. It will also examine changes which have occurred more recently with a view to making recommendations to Cabinet.

The NHS

The NHS was launched in 1948. It was born out of a long-held ideal that good healthcare should be available to all, regardless of wealth – a principle that remains at its core. With the exception of some charges, such as prescriptions and optical and dental services, the NHS in England remains free at the point of use for anyone who is a UK resident.

There are currently more than 66.6 million people in the UK, nearly 54 million people in England alone. The NHS in England deals with over 1 million patients every 36 hours. It covers everything from antenatal screening and routine screenings such as the NHS Health Check and treatments for long-term conditions, to transplants, emergency treatment and end-of-life care.

The NHS employs more than 1.5 million people, putting it in the top eight of the world's largest workforces together with the US Department of Defence, McDonalds, Walmart and the Chinese People's Liberation Army amongst others. The NHS in England is the largest part of the system by far, employing approximately 1.2 million people. Of those, the clinically qualified staff include approximately 106,430 doctors; 285,893 nurses and health visitors; 21,597 midwives; 132,673 scientific, therapeutic and technical staff; 19,772

ambulance staff; 21,139 managers; and 9,974 senior managers[1]. Nationally, it is estimated that GPs undertake approximately 90% of NHS activity for 7.5% of the cost, seeing more than 320 million patients each year.

In September 2016, there were (full-time equivalent): 15,827 nurses in GP practices; 10,009 GP direct patient care staff; and 65,334 admin/non-clinical staff. While the number of nurses in GP practices had increased by 429 (2.79%) since September 2015, the number of practice nurses declined by 67 (0.57%) over the same period. In March 2017, there were 33,423 full-time equivalent GPs (excluding locums), which is a reduction of 890 (2.59%) on March 2016[1].

Funding for the NHS comes directly from taxation. Since the NHS transformation in 2013, the NHS payment system has become underpinned by legislation. The Health and Social Care Act 2012 moves responsibility for pricing from the Department of Health, to a shared responsibility for NHS England and Monitor. When the NHS was launched in 1948, it had a budget of £437 million (roughly £9 billion at today's value). In 2017/18, planned spending for the Department of Health in England was around £124.7 billion.

GP Networks

General practice in England is under significant strain. Many GPs and their teams are struggling to meet the increasing pressures of decreasing resource and an increased burden of patients with long term conditions. Fundamental changes in the way the NHS works (financial rules and the creation of a competitive market) encourage competition between companies to bid for areas of work in the NHS and there are already a wealth of independent sector organisations providing services to patients under NHS contract.

An increasing number of GP practices are considering entering into some kind of collaborative arrangement with other practices. GP networks go by many names: federations, networks, collaborations, joint ventures, alliances. These terms are often used interchangeably to describe multiple practices coming together for a common goal. Whether this is driven by the desire to share costs and resources (for instance, workforce or facilities) or as a vehicle to bid for enhanced services contracts, providing general practice at scale is increasingly being viewed as the future of general practice.

The Hillingdon Primary Care Confederation has been created and HCCG has put measures in place to strengthen the existing GP Network infrastructure to support it to become fully operational and a more active provider of enhanced health care services. It is anticipated that this will ensure the GP community has the best opportunity to deliver consistently high quality healthcare to its local population. In 2017/2018, there were 46 GP practices in Hillingdon, 44 of which were members of the Hillingdon Confederation.

Joint Commissioning

In April 2017, full delegation of primary care commissioning authority was transferred from NHS England (NHSE) to HCCG. There are a number of benefits in exercising full delegation such as:

- Local management of medical contracts enables the CCG to offer more responsive 'customer care' to contractors and patients, grounded in better understanding of local needs.

[1] NHS Confederation - http://www.nhsconfed.org/resources/key-statistics-on-the-nhs

- Opportunity to develop closer relationships with a wide range of local stakeholders including local GP practices.
- Clearer lines of responsibilities and decision-making.
- More integrated strategic management of primary care enables a more joined up vision for primary care, which is aligned with the CCG's overall strategic objectives.
- Ability to manage primary care budgets locally that includes control of the CCG allocations, surpluses and various funding streams under GP Forward view.
- More flexibility in the design and development of Local Incentive Schemes that may include the development of alternatives to national Directed Enhanced Service (DES) or Quality and Outcomes Framework (QoF) if locally agreed.
- Full delegation may also help the development of new models of care as contracting with GPs networks and federations for a defined population requires a joined up local commissioning model, where a single, outcome-based contract may be agreed.
- Delegated commissioning also offers CCGs further opportunities to improve out-of-hospital services for local people and to support a shift in investment from the acute to primary and community settings.

In April 2106, NHSE set out plans to enable CCGs to commission and fund additional capacity across England to ensure that, by 2020 everyone has improved access to GP services including sufficient routine appointments at evenings and weekends to meet locally determined demand, alongside effective access to out of hours and urgent care services. In February 2018, NHSE published guidance which required CCGs to provide extended access to GP services, including at evenings and weekends, for 100% of their population by 1 October 2018. This must include ensuring access is available during peak times of demand including bank holidays and across the Easter, Christmas and New Year periods.

As pharmacists are well placed and well qualified, some GP networks have been engaging pharmacies with a view to help deliver long term conditions care. It is hoped that initiatives like this will enable GPs to have more time to deal with long term conditions and therefore provide continuity to patients.

To address the increased demand for hospital services, The Hillingdon Hospitals NHS Foundation Trust (THH) has been working with HCCG. A number of successful small pilots have been undertaken to provide better access to GPs and consideration is being given to how this can be scaled up across the Borough.

Better Care Fund (BCF)

The Better Care Fund (BCF) is thought to be one of the most ambitious programmes across the NHS and local government to date. It creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services, and shifting resources into social care and community services for the benefit of the people, communities and health and care systems.

In Hillingdon, the NHS and Hillingdon Council are looking for ways to improve the way that they work together as, when things go wrong, people can get stuck in hospital or be admitted to expensive nursing care when they would rather manage at home. A good example of where health care and social care need to work together is around agreeing the care needed at home to allow an older person to leave hospital sooner after a fall.

Work in Hillingdon includes a number of schemes which concentrate on:

- better services in communities
    - to provide support to people at risk of falls, dementia and/or social isolation
    - to offer better services at home for people who are terminally ill
    - to ensure that community services and GP practices work together more closely
    - to support people providing unpaid care for relatives or friends
- helping to prevent admissions to hospital
    - by offering good alternatives to the A&E service
    - by offering good community services every day of the week
    - by making it easier for GPs to keep an eye on people with more complex health needs
- getting people home quicker when they've been in hospital
    - by working better with care homes and nursing homes
    - by joining up the services we offer at people's homes

Challenges

GPs are currently facing a number of challenges and it is likely that improvements to the healthcare pathways will raise additional issues. These challenges include:

- the shortage in the number of individuals training to become a GP;
- the increasing population;
- the increasing acuity and number of conditions experienced by patients;
- the positive move to improve the health and social care pathway which will result in more patients being monitored by GPs;
- the increasing trend to move the care of people with long term conditions out of a hospital setting and closer to home at the GP surgery;
- the number of GPs that could retire in the next 5 years or move abroad; and
- Government proposals to ensure that everyone in England has access to GP services seven days a week.

Whilst the Council has limited direct responsibility in this area, the issues can still be reviewed locally with a view to making recommendations on behalf of the Council and residents.

Terms of Reference

The following Terms of Reference are proposed:

1. To review the evidence gathered by the GP Pressures Working Group in 2015/2016;
2. To understand the key / central current pressures that are faced by GPs;
3. To explore the possible implications for residents of expected changes to services provided by GPs;
4. To identify what support is currently in place for GPs and whether this level of support will be sufficient in the future;
5. To examine best practice elsewhere through case studies, policy ideas and witness sessions;
6. To explore ways in which services can improve and work more collaboratively to alleviate the pressures faced by GPs in the Borough, and recommend these to the appropriate body; and

7. After due consideration of the above, to bring forward recommendations to the Cabinet and, if required, the Health and Wellbeing Board, in relation to the review.

INFORMATION & ANALYSIS

Methodology

It is proposed that a Working Group be set up to examine background documents and receive evidence at its public and private meetings from officers and external witnesses. Research into relevant documents and websites would also be undertaken to provide background information for Members.

Witnesses

Possible witnesses include:

1. Local Medical Committee
2. GPs
3. Hillingdon Clinical Commissioning Group
4. The Hillingdon Hospitals NHS Foundation Trust
5. Public Health
6. Central and North West London NHS Foundation Trust
7. Healthwatch Hillingdon
8. GP Confederation
9. Local Pharmaceutical Committee

APPENDIX B

WITNESS, EVIDENCE & ASSESSMENT

The table below sets out the possible witnesses that could be invited to present evidence to the Committee. It is proposed that witnesses are invited to attend themed sessions to ensure that issues arising are dealt with comprehensively and strategically. Members are reminded that this is not an exhaustive list and that additional witnesses can be requested at any point throughout this review.

Meeting	Action	Purpose / Outcome
ESSC: 10 October 2018	The scoping report will be presented to the Committee. Members will have the opportunity to agree/amend the terms of reference and/or propose alternative/additional witnesses.	Information and analysis
Working Group: 1st Meeting - TBC	Introductory Report / Witness Session 1 To gain evidence from the GPs to establish the pressures that they are facing	Evidence and enquiry
Working Group: 2nd Meeting - TBC	Witness Session 2	Evidence and enquiry
Working Group: 3rd Meeting - TBC	Draft Final Report	Proposals – agree recommendations and final draft report
ESSC: TBC	The draft final report will be presented to the Committee by Chairman of the Working Group.	Consider Draft Final Report
Cabinet*:* TBC	The draft final report will be presented to Cabinet by the Chairman of the Committee.	Cabinet may approve, amend or reject as many of the report's recommendations as it wishes.

Members may also wish to consider whether appropriate site visits should be undertaken on areas in which they require further information.

Assessment

As is standard practice for a Policy Overview and Select Committee review, once a report's recommendations have been agreed by the Cabinet, officers will be asked to begin delivering the necessary changes. The monitoring of officers' work is a fundamentally important aspect of the Committee's work and, as such, regular reports on progress can be requested by Members and a full update report will be added to the future work programme of the Committee.

Resource requirements

This review will be undertaken within current resources. The plan set out above will be co-ordinated and delivered by Democratic Services. The additional resource of staff time required to present, collect and format evidence for witness sessions will also need to be considered.

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