

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Agenda

Tuesday 13 March 2018

7.00 pm

Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Administration:	Opposition
Councillor Rory Vaughan (Chair) Councillor David Morton Councillor Mercy Umeh	Councillor Andrew Brown Councillor Joe Carlebach
Co-optees	
Victoria Brignell, Action on Disability Debbie Domb, Disabilities Campaigner Jim Greal, Save Our Hospitals Bryan Naylor, Age UK	

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Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

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13 March 2018

<u>Item</u>		<u>Pages</u>
1.	MINUTES OF THE PREVIOUS MEETING	1 - 15
	(a) To approve as an accurate record and the Chair to sign the minutes of the meeting of the Health, Adult Social Care and Social Inclusion PAC held on 30 th January 2018	
	(b) To note the outstanding actions.	
2.	APOLOGIES FOR ABSENCE	
3.	DECLARATION OF INTEREST	

If a Councillor has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent.

At meetings where members of the public are allowed to be in attendance and speak, any Councillor with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Councillor must then withdraw immediately from the meeting before the matter is discussed and any vote taken.

Where Members of the public are not allowed to be in attendance and speak, then the Councillor with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Councillors who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest.

Councillors are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Audit, Pensions and Standards Committee.

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| 4. | NW LONDON COLLABORATIVE CCGS SHADOW JOINT COMMITTEE TERMS OF REFERENCE | Verbal / To Follow |
| | This item will consider and discuss the governance arrangements currently being considered by the North-West London Collaboration of Clinical Commissioning Groups Shadow Joint Committee, and its proposed terms of reference. | |
| 5. | IMPERIAL COLLEGE NHS TRUST: CARE QUALITY COMMISSION INSPECTION REPORT FEBRUARY 2018 | 16 - 80 |
| | This report relates to the Care Quality Commission's (CQC) inspection report on Imperial College NHS Trust, published in February 2018. The CQC report recognises improvement in some areas but the overall rating is unchanged at 'Requires improvement'. | |
| 6. | IMPROVING TRANSITIONS - TASK GROUP FINAL REPORT | 81 - 103 |
| | This report makes recommendations to improve the experience for young disabled people transitioning from social care services for children, to social care services for adults. | |
| 7. | WORK PROGRAMME | 104 - 105 |
| | The Committee is asked to consider its work programme for the remainder of the municipal year. | |
| 8. | DATES OF FUTURE MEETINGS | |
| | Date to be confirmed. | |

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee Draft Minutes

Tuesday 30 January 2018

PRESENT

Committee members: Councillors Rory Vaughan (Chair), Joe Carlebach, David Morton and Mercy Umeh

Co-opted members: Victoria Brignell (Action on Disability), Jim Greal (Save Our Hospitals) and Bryan Naylor (Age UK)

Other Councillors: Ben Coleman, Cabinet Member for Health and Adult Social Care.

Officers: Olivia Clymer, Chief Executive, Healthwatch; Kim Dero, Chief Executive, LBHF; Prakash Daryanani, Head of Finance, ASC; Gaynor Driscoll, Head of Public Health Commissioning; Emily Hill, Head of Corporate Finance; Hitesh Jolapara, Strategic Director of Finance; David McNulty, Programme Manager, HCH Finance and Resources; Eva Psychrani, Engagement Lead, LBHF, Healthwatch; Lisa Redfern, Director of Adult Social Care; and Richard Simpson, Public Health Finance Manager; Peter Smith, Head of Policy & Strategy, Dr Tim Spicer, Chair, H&F CCG

169. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting were agreed as an accurate record, subject to an amendment to the inclusion of the following text, under Minute 165. Developing Further Collaborative Working Across NW London CCGs:

“Councillor Coleman was worried that a majority vote of members of the Joint Committee could impose decisions on CCGs who disagreed. He was particularly concerned about this with regard to acute services. Vanessa Andreae said they preferred a consensual approach to decision making”.

170. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Andrew Brown and Co-optee Debbie Domb.

171. DECLARATION OF INTEREST

None.

172. APPOINTMENT OF CO-OPTEE

Councillor Vaughan welcomed Victoria Brignell to the meeting. With an active interest in the issues affecting disabled people, Ms Brignell had been a member of the Disabled Peoples Commission and helped produce their report on co-producing local services; and was Chair of the charity, Action on Disability.

RESOLVED

That Victoria Brignell be appointed as a co-optee to the Health, Adult Social Care and Social Inclusion Policy and Accountability Committee for the remainder of the municipal year 2017/18.

173. FUNDING OF GP PRACTICES IN HAMMERSMITH & FULHAM

Dr David Wingfield briefly outlined concerns set out in a letter from the GP Federation to the CCG, and their subsequent response (included as Appendices 1 and 2, respectively). The GP Federation had worked closely with the CCG. Dr Wingfield explained that in addition to leading three practices in the Borough, he had also been a resident for 25 years. The practices were an intricate business, with a cash limited budget funding nursing and GP services which could not be over-extended. Local funding had historically been low and a “catch up” programme of investment was in place to address this. Dr Wingfield queried with the CCG the slow pace of delivering investment. The GP Federation had worked with the CCG to develop the Primary Care Strategy (published September 2017) but felt that there had been lost opportunities.

Janet Cree referenced the CCG letter of response from Clare Parker, Accountable Officer, NWL CCG, and affirmed that the CCG continued to work closely with the GP Federation. This had been a challenging year and the first year in which the CCG had received primary care delegated funding. They had worked hard to discharge their responsibilities as efficiently as possible. Considerable progress made and approximately £1.134 million had been spent. Collectively, she felt that good progress had been made. £600,000 was committed to ensure sustainable primary care, as set out in the Primary Care Strategy, and continued to be a priority. It was a challenge to ensure that accountability remained and that money was being invested for the benefit of the intended recipients.

Councillor Carlebach sought clarification about the distinction between the role of the CCG and that of GPs, with the CCG as commissioners. Janet

Cree explained that the CCG comprised of member GP practices, with a governing body having oversight of commissioning. GPs were also providers, delivering primary care services to patients and the GP Federation covered the provider aspect, with the CCG having delegated powers to delivery primary care.

Councillor David Morton sought clarification regarding the headroom fund 2017/18 and whether it need to be spent this financial year and what the financial risks were if it could not be carried over. Janet Cree responded that there was a plan to spend the money within the financial year.

In response to a question from Bryan Naylor, it was explained that £1.34 million of the budget had been allocated. While he appreciated the complexities, Bryan Naylor observed that nine months into the financial year, very little of the money had been received. Janet Cree explained that the CCG were currently awaiting invoices from GP practices. £605,000 had been allocated but the CCG awaited the receipt of invoices, before funds could be released. To date, £190,000 had been paid, the precise detail of which she did not have but could be provided. Janet Cree disagreed that funding had not been allocated or spent, and clarified that the areas highlighted in Dr Wingfield's letter had been agreed as the focus of the investment.

Acknowledging Dr Wingfield's comment that home care and complex care were not separate from the proposals, Bryan Naylor sought further clarification as to why the funding had been delayed for 9 months. Vanessa Andreae explained that headroom money must be seen in context with primary care strategy and that the CCG had been waiting for this to be allocated and flow. She continued, recognising the frustration this caused, but stated that it took time to get practices to work together. The CCG could not impose practices on GPs, they must work together.

Jim Grealy welcomed the discussion initiated by the GP Federation and Dr Wingfield on the provision of primary healthcare to residents in the borough. He appreciated that there was a flow of money but pointed out that key decisions were not being made in the Borough, but elsewhere. Citing the example of Ealing, which had rolled out funding and with the on-going winter crisis, he did not feel confident. He suggested that the GP Federation draw up a list of what they wanted to achieve in the Borough.

Dr Tim Spicer, Chair, H&F CCG, conveyed how the CCG had worked hard with the GP network to deliver a joint primary care strategy. They had achieved something that very few other CCGs had done, developing a strong and mature network. Vanessa Andreae added that primary care commissioning would remaining localised, with any conflicts managed through a local conflict resolution committee.

Jim Grealy reiterated his earlier view and observed that he found it impossible to explain to members of the public why money had been allocated so late in the year. The winter crisis was an anticipated annual occurrence that could have been planned for utilising this funding.

Victoria Brignell concurred with this prevailing concern and asked, with two months to the end of the financial year, how easy would it be to spend in the intervening period. She asked how funding would be invested in staff and how this recruitment would be managed. Janet Cree confirmed that money was being invested in both primary care and in staff, with £600,000 committed in 2017/18, which would continue into 2018/19.

Dr Wingfield emphasised that the formation of GP networks was a model that had gradually been built up in the last 7 years. The pace of development this year had increased notably. However, the pace of collaboration and of investment had not aligned. Responding to an earlier reference to staffing, he explained that to recruit short-term staff to release other staff for long term projects was not an ideal approach, advocating a preference for permanent staff.

Councillor Coleman considered the allocation of £1.35 million, noting that approval was being sought for approximately £588,000 and sought clarification as to whether the budget for 2017/18 would be rolled forward into 2018/19. Vanessa Andreae confirmed that there was a shortfall of £170,000 for the current financial year, but reported that there would be further allocations at a future committee meeting. The pace of work had been rapid but everything would be put in place by October 2018. Councillor Coleman asked how long it would be before the £1.3 million would be spent. Janet Cree reiterated that the allocated funding was public money, requiring appropriate governance and approval mechanisms. There was an expectation that invoices would be provided by GPs in the coming months.

Dr Wingfield, in response to a follow up query from Cllr Coleman, contended that it was difficult to estimate the possible time it required to “spend” the allocation. This was late in the day, given the combined concerns of recruitment, delivering care, and measured outcomes. Dr Wingfield added that he thought it unlikely that the money could be spent and that they would be doing well to have spent half of this by March 2018, with the added caveat that some of the work needed was to lay foundations for new ways of working. Some of this work would not see outcomes by March and part of the discussion with the CCG was to identify what those outcomes were.

In response, Janet Cree explained that there was an assessment process to evaluate bids, which was partly the reason expenditure had been part of the budget setting process, accepting that some submitted bids were not achievable. Recognising the inherent challenges, she felt confident that the £1.35 million could be spent. A primary care commissioning committee was due to meet on 13th February, and she acknowledged that there remained some governance procedures to conclude.

Discussing the possibility of a further meeting to review if the money had been spent, Councillor Morton suggested that it would have been helpful to have had this considered by the Health and Wellbeing Board (HWB). Councillor Coleman confirmed that this issue had arisen after the last meeting of the Board (November 2017). Janet Cree provided further context and clarified that the issue was about delivery of the primary care strategy and that the subject had been fully discussed at HWB. In a wider context, this

was also a North-West London governance issue. Decision making about primary care was local but there was a broader, budgetary process to consider. Primary care was not sufficiently robust to meet Sustainability and Transformation Plan (STP) needs and required further modelling and a wider strategic discussion.

Merrill Hammer (Save Our Hospitals campaign) asked what the alternative would be if the entire spend was not utilised and whether the CCG would have to account for monies not spent. Janet Cree explained that overall, they were currently forecasting to be on budget, with support from other CCGs and that they were not in an underspend position.

Councillor Vaughan speculated that some invoices for work already commissioned up to £1.35 million had been issued and expected that this would meet targets out of the headroom fund. Janet Cree explained that they were working on the implementation of the CCG programme of investment in general practice, meeting regularly with GPs. The actual mechanism was working and the question of headroom would occur next year, with the process commencing earlier.

Councillor Coleman asked whether funding could be invested in the Community Independence Service (CIS). Janet Cree replied that the CCG was already investing in primary care and although she could not commit primary care money to the CIS, the CCG would be happy to work with the Council on this. Lisa Redfern, Director ASC added that they were already working with the CCG on homecare, providing services for the vulnerable and elderly. ASC was well placed to assist and she confirmed that they would be happy to continue to work with the CCG.

Kim Dero, Chief Executive, LBHF, sought clarification about the submission of invoices and asked whether activity had already commenced and if there was an expectation that GPs will be delivering this in the next 6 weeks or if it would continue into the coming financial year. Janet Cree confirmed that it would be a combination of the two. Responding to a follow up question regarding the percentage of the funding pot that had been allocated and how much was going to be spent, Janet Cree confirmed that these figures could be provided. Vanessa Andreae added that some of this was about setting up processes for next year, so work was in train for 2018/19, and, about practices organising themselves to deliver in the next financial year.

In summarising the key points of the discussion, Councillor Vaughan observed that there were inherent difficulties in allocating funds, noting that both the CCG and the GP Federation had worked diligently to resolve this, recognising the additional concerns and pressures about the process and time taken to reach this point. It was agreed that this would be brought back for further discussion at a future meeting.

RESOLVED

That the report be noted and the issue be reviewed at a future meeting.

174. A REPORT ON H&F COUNCIL'S EMERGENCY RESPONSE TO MAJOR INCIDENTS IN JUNE AND SEPTEMBER 2017

The Chair welcomed Peter Smith, Head of Policy, who presented a report, together with Kim Dero, Chief Executive and David McNulty, Programme Manager, HCH Finance and Resources. The report covered the Council's response to two recent major incidents affecting residents and visitors to this and the neighbouring borough of RBKC. The Grenfell Tower fire had resulted in a tragic loss of life and the report acknowledged that there may be criminal charges and on-going enquiries. The report also examined a second incident which took place at Parsons Green Tube Station. The report looked solely at the response of the Council as an organisation and had been previously discussed at Audit Committee and Policy and Accountability Committee scrutiny meetings. The report identified what was done well, and made recommendations for further actions.

Councillor Joe Carlebach welcomed the report but commented that with regards to the Parsons Green incident, he was aware of children travelling through the area and little assistance being made available to those children. One child was particularly traumatised. Councillor Carlebach suggested that where there were reports of people traumatised from serious experiences, the Council should consider what support could be immediately implemented in the aftermath.

Councillor Carlebach also reported that The Real Community Grenfell charity, which worked with survivors living in the Borough, had experienced great difficulties in finding accommodation within the Borough. He asked if officers could offer any assistance in exploring options for a more permanent location for the group.

Kim Dero explained that she had worked with Nick Austin, Bi-Borough Director for Environmental Health, and David McNulty, in the preparation of the report. Referencing earlier comments about which committees had considered the report, it was confirmed that at the Children and Education Policy Accountability Committee, three local head teachers had attended and recounted the incident and resulting trauma. This was new for all those involved but agreement was reached to work with schools, in future. Council officers and social workers had liaised well with affected schools, particularly Lady Margaret School, located closest to the Station.

Responding to Councillor Carlebach's second point, Kim Dero reported that 27 families were resident in hotels, located in LBHF, awaiting accommodation offers from RBKC. She continued, that the Council had wanted to make space available but had been unable to successfully manage a more permanent base for The Real Community charity.

Councillor Mercy Umeh highlighted the work of people based on the Edward Woods estate and the allocation of charitable goods and money raised for survivors. Kim Dero acknowledged that Hammersmith Town Hall had been inundated from day one, when 10-11,000 items were received. The Council

had never managed donations before and people had spontaneously brought and donated items. A hackathon was organised, bringing together community organisations, involving 140 people, to discuss community strength and resilience. To illustrate, a lot of fresh food had been donated, much of which was wasted because many were fasting at the time of the incident. Given the size and nature of the response, the people, community, and businesses involved, the Council had played a small part in responding to what followed.

Councillor David Morton observed that assistance had been provided to one of the wealthiest Boroughs in the country (RBKC). He asked if there had been any calculations or assessment as to the cost of the safety checks undertaken following Grenfell; and whether any costs could be reimbursed, referring to Bellwin. Dealing with the cost of safety question first, Kim Dero explained that there were two aspects to this. There had been numerous calls from residents on the Edward Woods Estate, who were subsequently reassured. The second aspect was to conduct fire safety checks, a primary consideration, as set out in the report. David McNulty explained that £20 million in funding had been set aside to ensure safety checks, with 71 blocks in total assessed. Information was made available on the Council website from August 2017 which included housing management fire safety checks. A proactive approach was adopted for a capital works programme, to ensure that fire hazards were identified and the requisite fire checks conducted. Fire Safety Plus was an offer to visit people's homes to look at arrangements in the home, check electrical goods and smoke alarms. This reflected an on-going commitment to work with residents.

Councillor Morton commented that the Borough (RBKC) had a small amount of council tenants. There were also many private tenants who would bear the brunt of costs to install safety measures. He was concerned that there was a hidden cost that was being passed on to residents. David McNulty agreed, noting that standards across the board would change. It was anticipated that the enquiry would establish the final cost and that the Bellwin scheme might require an application to central government.

Emily Hill, Head of Corporate Finance, clarified that the aim of the Bellwin scheme was to aid. RBKC could claim for additional costs under strict rules. This precluded existing staff, but covered overtime. It also applied to LBHF, however, claims could only be submitted within a two-week period following an incident. A mutual aid agreement with London boroughs was in place but it was difficult to quantify actual costs which will need high level analysis. Given the tri and bi-borough shared service arrangements it was difficult to establish which "hat" they were wearing, placing limitations as to what could be claimed.

Co-optee Victoria Brignell expressed disappointment as to the lack of explicit reference to people with disabilities, for example, any wheelchair users evacuated in the emergency. She suggested that the Council explore what resources and facilities such as lifts, hoists and additional equipment might be needed. It was recommended that the Council speak to local people with disabilities. An app had been produced to see what resources were available to help disabled people, in an emergency. David McNulty agreed that they

would make the report more specific. They also planned to identify vulnerable people from existing Council records and were currently reviewing emergency and continuity plans, which would benefit from a co-production approach. Councillor Coleman endorsed Victoria Brignell's suggestion and emphasised the importance of co-producing this work.

Given the difficulty for elderly and vulnerable people to get to street level without lift or escalator access at Parsons Green station, Jim Grealy suggested that the Council approached Transport for London, and strongly advocate the need for more suitable access to station platforms. David McNulty welcomed the suggestion but explained that in an evacuation, lifts and escalators would not be operational.

Councillor Coleman welcomed the report and expressed hope that the Grenfell enquiry would seek evidence from the Council. The report clearly portrayed the challenges for the Council, with considerable pressure resulting from shared service issues and costs. He commended the remarkable response of Council officers and the wider community.

Referencing section 3.3 of the report, Cllr Coleman highlighted the Leader of the Council's statement that any survivor would be regarded as a resident of the Borough in terms of immediate support. Council officers had visited hotels across the Borough, finding displaced people, offering support and assistance, such as food vouchers. Officers had taken the initiative to arrange vouchers with local restaurants so families could have varied food. Cllr Coleman said that hoteliers had not been equipped to deal with traumatised people, about which he had received daily reports.

Councillor Coleman said that the £20 million which LBHF had allocated would cover the cost of fitting of fire doors both for tenants and for leaseholders. He was delighted that the money was being invested in ensuring the safety of residents and welcomed the report's recommendations of having a clear policy for supporting Disabled people.

Cllr Coleman said he was very impressed by the way in which the Council and local community had responded during a difficult time. He commended officers, who had done an extraordinary job under challenging circumstances, and expressed his personal thanks to officers and residents.

Councillor Vaughan welcomed the report, and echoed Councillor Coleman's thanks to officers and residents. The importance of this detailed report was to learn lessons, so that the Council was well equipped to respond. Referring to an earlier point regarding the evacuation of Disabled people, he hoped and anticipated that this could be addressed, particularly in light of the recent Disabled People's Commission's work on co-production.

RESOLVED

1. That the Health, Adult Social Care and Social Inclusion Policy and Accountability Committee endorse the recommendations of the report; and
2. That the Committee note the report.

175. HEALTHWATCH UPDATE

Councillor Vaughan welcomed Olivia Clymer, Chief Executive, and Eva Pyschrani, Engagement Lead, from Healthwatch. Olivia Clymer explained that the report set out the research undertaken to evaluate patient and community views about the future of Charing Cross Hospital, because of the lack of clarity about what the future held for a valued and cherished organisation. The methodology of the survey framed questions submitted to NWL CCGs and was then asked of local people. Two pieces of outreach work were undertaken to understand the experience of people using Charing Cross.

The report considered patient involvement, experience, treatment, communication, travel time and patient perceptions of what a local hospital was. The methodology meant that the questions went to the CCG, then out in the field, and to the hospital, to capture responses of the public.

There was overwhelmingly positive appreciation of the hospital. Patients said that they wanted to be involved in shaping the future of the hospital. In its conclusion, the report emphasised that the Charing Cross was an important part of the community for local people.

Councillor Morton said that he felt reassured by the report and that services would be safe until 2021. However, given that borough was estimated to increase by 15,000 people, he sought stronger assurances to address future provision. Olivia Clymer concurred but explained that it was not within the gift of Healthwatch to do so. They could help scrutinise how decisions about health services were being made and hold NHS decision makers to account. They were currently awaiting a response from the NWL collaborative.

Janet Cree said that this was an excellent report and suggested that it be included on the Imperial College Healthcare NHS Trust (Imperial) board meeting agenda. It was important to hear residents' concerns and how much they value the hospital, and the CCG offered to assist with facilitating this.

Bryan Naylor commended the report but queried the small sample size of the survey, expressing concern that it would be too easy to dismiss because of the small number of respondents. He suggested that it would benefit from further work, which would lend it more weight. Victoria Brignell added that given how the NHS was stretched, why even contemplate closing Charing Cross, forcing people to travel further for treatment?

Olivia Clymer welcomed the positive comments provided. This was a robust piece of work, with a simple, clear message. She indicated that she would like to see how recommendations could be taken forward.

Jim Grealy thanked Healthwatch for a thorough piece of work, which represented what long-term patients and residents already recognised and highlighted concerns about losing Charing Cross, which would not diminish. He said that the hospital was not replaceable and it would be helpful to see an accurate report on the demographic developments in this part of London, referencing the needs of an ageing population, which must be considered.

He said there had been no new thinking since Shaping a Healthier Future (SaHF) and the STP. Evidence regarding travel for vulnerable people to get treatment had not been provided and there was a need for specific answers and evidence, as to when Charing Cross was to close.

Bryan Naylor, using the winter crisis as a reference, suggested the inclusion of a further recommendation that would allow earlier engagement when major decisions were being considered at a formative stage, so for the STP, this was now. Two-way dialogue was needed, where the views of local people informed future plans.

Eva Pyschrani suggested that it might be feasible for Imperial to prepare a demographic report at the request of the Committee.

In terms of recommendations, Olivia Clymer highlighted the need for a clear and robust communication and engagement strategy. The views of the CCG as to the definition of “consultation” was different from what residents understood.

The second recommendation was that the key NHS decision-making bodies should provide clear information in respect of decisions regarding the future of Charing Cross. 2021 was only three years away and she suggested that a decision should be reached or the plans rescinded to allow greater clarity. In concluding, Olivia Clymer invited the Committee to hold the CCG to account, and encouraged the CCG to work collectively in a framework of engagement.

In response to a request from Councillor Coleman, Janet Cree confirmed that she would facilitate the report’s inclusion on the agenda of the next Imperial board meeting and the next NWL Collaborative CCG shadow joint committee. It was explained that the latter would hold its first meeting on 1st February. Councillor Coleman commented that the joint committee would have delegated powers to close the Charing Cross. Dr Tim Spicer responded that there had never been a suggestion that Charing Cross would be closed.

Councillor Coleman observed that it was appropriate that Imperial board members considered the report, so that residents’ views could be heard. The NHS was too undemocratic, unresponsive and poor at consultation. It was suggested that the report also be sent to all eight of the West London Alliance councils.

Councillor Coleman said it was important to understand the criteria being employed by the NHS to reach their conclusions about Charing Cross and that the criteria needed to be transparent. Dr Tim Spicer responded that the survey had been undertaken with people attending outpatient clinics, so it was appropriate that they would be seen at a local hospital. He suggested that the survey be broadened to capture the views of inpatients.

Referencing the predicted population increase within the Borough, with increased numbers of vulnerable people, Councillor Coleman expressed concern that Charing Cross might be overwhelmed without more investment. Initiatives such as the Community Independence Service (CIS) helped alleviate pressure but further work was required.

Jim Grealy added that if the intention was to downgrade Charing Cross from an acute to a local hospital after 2021, then consultation should begin now to allow the public to have a full input, during the intervening period.

In summarising the discussion, Councillor Vaughan, noted that the report would be further considered by Imperial and the Collaborative CCGs shadow joint committee. On the issue of engagement, Councillor Vaughan reiterated the need for proper consultation and that it would be interesting to see shape of future engagement plans.

RESOLVED

1. That the report be provided to Imperial College Healthcare NHS Trust and the NWL Collaborative CCGs shadow joint committee; and
2. That the report be noted.

176. 2018 MEDIUM TERM FINANCIAL STRATEGY (MTFS) - ADULT SOCIAL CARE

Councillor Vaughan welcomed Hitesh Jolapara, Strategic Finance Director and Emily Hill, Head of Corporate Finance. In addition to providing a corporate perspective, the presentation provided an overview of the MTFS for Adult Social Care (ASC). The national real terms department budget changes indicated significant growth. For example, ASC increased by 10% starting in 2010, with everything else in decline. Funding in real terms from the Department for Communities and Local Government (DCLG), had decreased significantly over 2010-16. Local Government expenditure GDP (Gross Domestic Product) was 6.5% in 2010, decreasing to 4.5% in 2016, with a downwards trend continuing to 2022 and beyond.

Pension budgets nationally increased by 34% in cash terms, but cash for ASC nationally had flatlined and reduced slightly. Since 2010/11, a reduction in government grant of £70 million reflected a 54% reduction in real terms. Plans to localise national non-domestic rates (NNDR) had been shelved, however London was one of several areas within a pilot scheme, which was on-going and NNDR for London had just been agreed (a potential benefit of £2.6 million). Review of fair funding for local authorities analysed all key parts of the funding formula and was briefly explained. Loss of funding for London, was often a gain to the shires.

Budget papers were subject to formal agreement at the February Budget Council meeting. The approach was to freeze Council Tax again, and not to apply the ASC precept. Nationally there were assumptions around this, Government modelling for the 2018/19 LGFS assumed 3% Council tax increase, which was likely to be the case with most other local authorities.

The Westfield Expansion would bring in £2.2 million; and statutory fees and charges for parking, children, adults, and housing would be frozen, unless a statutory increase was levied. Developer contributions from S.106 funding amounted to £1.7 million and would fund more police officers in the borough.

Referring to the H&F resources forecast, a 2% increase had been budgeted for with assumed expenditure such as pay inflation. For financial planning, a headroom of £6 million per annum was assumed from 2019/20 onwards, to allow for increased costs of care packages and in costs imposed by providers.

Hitesh Jolapara explained that budget setting was not just about income or efficiencies, but allowed for growth, highlighting the £1.3 million Better Care Funding (BCF) input. Focusing on a high-level summary of income for next year, it was explained that there was £2.9 million in growth across all departments. The Finance and Development Policy and Accountability Committee had considered a full set of budget papers. This was a balanced budget, but cumulatively there was a huge challenge of meeting a £40 million funding gap.

Lisa Redfern, Director for Adult Social Care presented the MTFs for ASC, providing an overview of challenges and achievements. ASC's key purpose was to promote independent care for residents and to keep people at home for as long as possible. Funding for ASC had decreased since 2010 but demand for services had increased. More people lived alone, with greater acuity of need, requiring a high level of care to enable them to live at home which was costly as the cost of care continued to rise. ASC wanted to ensure high quality of care standards, which required an enhanced performance framework, aiming for outstanding care rather than just good. Public perceptions of what constituted a good standard of care had also changed. Delayed discharge was being addressed to ensure that people spent less time in hospital. People came out of hospital with huge care needs, but the cost was lower to the NHS, although this created new challenges for the ASC budget. Ensuring a high quality workforce was a challenge in ASC across the board.

Lisa Redfern said that she was very proud of what had been achieved by ASC, delivering successes with less money and more demand. No resident in the Borough had been charged for home care since 2015, and this had been achieved within a balanced budget and with efficiencies. Services addressing delayed discharges had been both responsive and high performing. CIS had been nominated for two Local Government Chronicle awards.

Lisa Redfern said a balanced budget continued to be increasingly demanding but had been managed for 2017/18; and despite obstacles and with continuous improvement, many good achievements had been possible. She said the savings strategy consisted of four overall strands:

1. FDDM – Joint Front Door Demand Management, less siloed working across service teams; and smarter working, utilising new technology;
2. Commissioning strategy – Redesign of care pathways, for example;
3. Whole systems and integrated service offer – Considerable work was required to shift the focus to integrated care; and
4. Review of workforce costs – Efficient working.

Prakash Daryanani, Head of Finance (ASC) provided a corresponding financial perspective. The ASC Medium Term Transformation and Savings Strategy amounted to 19% of the total strategy. He said there were opportunities to make savings, arising from the disaggregation of the tri-borough services. To illustrate, there could be closer working with Public Services Reform (PSR) and Children's Services and services such as CIS, which had worked well. The risk to the ASC budget was that it was a demand-led service. This had to date been managed well. However, the year-on-year increase in demand, the risks around health budgets, increased inflationary costs and the London Living Wage presented significant challenges.

Prakash Daryanani provided budget headlines for 2018/19, highlighting ASC net expenditure budget 2017/18 of £59.353 million, and extra Council funding to cover London and national wage increases and market pressures of £1.249 million. In terms of the ASC gross spend, 15% was spent in-house for services, with staff and back office running costs amounting to 4% of the spend, and 70% used to fund externally provided community services. The overall trend analysis indicated an 11% increase in spending, with a reduction in the baseline budget and an increase in direct payments. There was no change to fees and charges.

At 9.58pm, the Committee agreed to suspend the guillotine and the meeting was extended to 10.30pm, to allow for the conclusion of remaining business.

Councillor Carlebach sought clarification regarding the reasoning behind the non-application of the social care precept. He was surprised, given that other councils of all political colours were applying this. Councillor Coleman responded that the Administration at the last election had promised to reduce council tax and keep it low, and it was keeping its promise.

Bryan Naylor highlighted concerns about social isolation and loneliness. He stated that there were 195,000 older people living in the Borough, which was estimated to grow by 34%, by 2040. The Older People's Commission (OPC) recognised that 75% of older people said they were lonely. The cost of addressing this would fall to ASC, with the financial benefits being accrued by the NHS. He observed that health services took the view that older people "bed block" and increased costs as a result. The perception amongst older people was that the number of step-down beds was being reduced and he asked if this was a trend.

Lisa Redfern explained that they were working with health colleagues and carers, to enable greater prevention measures. She acknowledged that they needed to get better at tackling issues earlier, including how cases were identified. It was becoming increasingly important to look for more creative solutions, as a community and tackle social isolation and loneliness. This was a critical area of work both for the Administration and for the Health and Wellbeing Board.

The increase in demand was also a critical factor and current funding did not meet the costs of essential care, which continued to be an incredible challenge. Lisa Redfern explained that more step-down beds had been

purchased. However, availability and quality continued to be a concern. The *State of Social Care Report 2016* indicated that 80% of residential and nursing home beds were Care Quality Commission rated as good but there were variations in industry standards.

Victoria Brignell thanked the Administration for abolishing homecare charges. Referencing her personal experience, she highlighted worrying concerns regarding inconsistencies in areas of responsibility and the demarcation between ASC and Health services. Lisa Redfern apologised for any distress this had caused and offered to assist, following the meeting. It was explained that some high-level care packages were funded by health and some were jointly funded. Lisa Redfern provided assurances that if health funding was not offered, ASC retained a duty of care.

Bryan Naylor commented that one factor that reduced demand was navigating the care pathway, for which proper guidance was needed. Lisa Redfern welcomed the comment and suggested that this be addressed by the OPC in their ongoing work.

Councillor Vaughan thanked officers for their presentation and commended the achievements made by the service, despite significant and debilitating funding reductions.

RESOLVED

That the report be noted.

177. 2018 MEDIUM TERM FINANCIAL STRATEGY (MTFS) – PUBLIC HEALTH

Councillor Vaughan welcomed Richard Simpson, Public Health Finance Manager, and Gaynor Driscoll, Head of Public Health Commissioning Adults, to present the MTFS for Public Health. Richard Simpson reported that challenges remained to achieve more for less, with numerous competing demands. The aim was to provide support in the most impactful way for residents, to maximise outcomes, with a decreasing amount of funding, with better value.

It was explained that Public Health grant funding for 2018/19 had been reduced by £600,000, requiring further savings. One outcome was to use the budget in fresh ways, particularly given the establishment of the Public Services Reform directorate. This meant working more closely with community groups, residents, and other key stakeholders in health.

They had achieved a significant amount of savings within the MTFS, with closer contract management, monitoring and service redesign. To illustrate, the smoking cessation programme had achieved the second highest results in London, and the third highest nationally. The Community Champion programme engaged with 500 people in the Borough. This was an uplifting programme about how communities could drive change. A total of £6 million in funding had been released to support projects across the Borough in addition to these commissioned services.

Richard Simpson explained in more detail the savings required to balance the loss of grant funding and how these had been negotiated. £22.8 million was the planned expenditure for 2018/19, with a substantial sum of £6m as above sitting in the transformation budget, allowing Public Health to capitalise on opportunities across the whole council as a result.

Richard Simpson said grant certainty in the short-term mitigated some of the risks. Despite unpredictable risks and opportunities, a balanced budget for 2018/19 was assured.

Janet Cree nquired about family and children’s funding, specifically, obesity contracts. Referencing p161 of the report, Richard Simpson replied that obesity had been identified as a public health priority, although specific contracts would expire and the work would be undertaken jointly in other services.

Councillor Vaughan thanked officers for a detailed and informative presentation, and acknowledged that significant outcomes continued to be delivered through the way in which Public Health had re-engineered provision across the borough.

RESOLVED

That the report be noted.

178. WORK PROGRAMME

RESOLVED

That the Work Programme be noted.

179. DATES OF FUTURE MEETINGS


The date of the next meeting was noted as Tuesday, 13th March 2018.

Meeting started: 7pm
Meeting ended: 10:30pm

Chair

Contact officer: Bathsheba Mall
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Governance and Scrutiny
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Agenda Item 5

<p>London Borough of Hammersmith & Fulham</p> <p>HEALTH, ADULT SOCIAL CARE & SOCIAL INCLUSION POLICY & ACCOUNTABILITY</p> <p>13 March 2018</p>	
IMPERIAL COLLEGE NHS TRUST: CARE QUALITY COMMISSION INSPECTION REPORT FEBRUARY 2018	
Report of Imperial College NHS Trust	
Open Report	
Classification - For Policy & Accountability Review & Comment Key Decision: No	
Wards Affected: ALL	
Accountable Director: n/a	
Report Author: Imperial College NHS Trust	Contact Details: E-mail: mick.fisher@imperial.nhs.uk

1. EXECUTIVE SUMMARY

- 1.1. This report relates to the Care Quality Commission's (CQC) inspection report on Imperial College NHS Trust, published in February 2018. The CQC report recognises improvement in some areas but the overall rating is unchanged at 'Requires improvement'.

2. RECOMMENDATIONS

That the Committee consider the report and appendices.

3. INTRODUCTION AND BACKGROUND

- 3.1. The Committee is asked to review documents attached as Appendix 1, Imperial College NHS Trust response to the findings of the CQC Inspection Report, and, Appendix 2, the Care Quality Commissions Inspection Reports Executive Summary, published February 2018.

4. CONSULTATION

- 4.1. N/A

5. EQUALITY IMPLICATIONS

- 5.1. N/A

6. LEGAL IMPLICATIONS

6.1. N/A

7. FINANCIAL AND RESOURCES IMPLICATIONS

7.1. N/A

11. IMPLICATIONS FOR BUSINESS

11.1 N/A

12. RISK MANAGEMENT

12.1 N/A

13. PROCUREMENT AND IT STRATEGY IMPLICATIONS

13.1 N/A

LOCAL GOVERNMENT ACT 2000

LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

Appendix 1: Imperial College NHS Trust response to the findings of the CQC Inspection Report

Appendix 2: Care Quality Commissions Inspection Reports Executive Summary, published February 2018

Care Quality Commission Inspection Report

Report from Imperial College Healthcare NHS Trust to the London Borough of Hammersmith & Fulham Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

1. Summary

This report to the Health, Adult Social Care and Social Inclusion Policy and Accountability Committee from Imperial College Healthcare NHS Trust (the Trust) relates to the Care Quality Commission's (CQC) inspection report on the Trust published in February 2018. The CQC report recognises improvement while the overall rating is unchanged at 'Requires improvement'.

2. Imperial College Healthcare NHS Trust overview

The Trust provides acute and specialist healthcare for a population of nearly two million people in North West London, and more beyond. We have five hospitals – Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and Western Eye – as well as a growing number of community services.

With our academic partner, Imperial College London, we are a founding member of one of the UK's six academic health science centres (now expanded to include Royal Brompton & Harefield NHS Foundation Trust and the Royal Marsden NHS Foundation Trust), working to ensure the rapid translation of research into better patient care and excellence in education. We are also part of Imperial College Health Partners, the academic health science network for North West London, spreading innovation and best practice in healthcare more widely across our region.

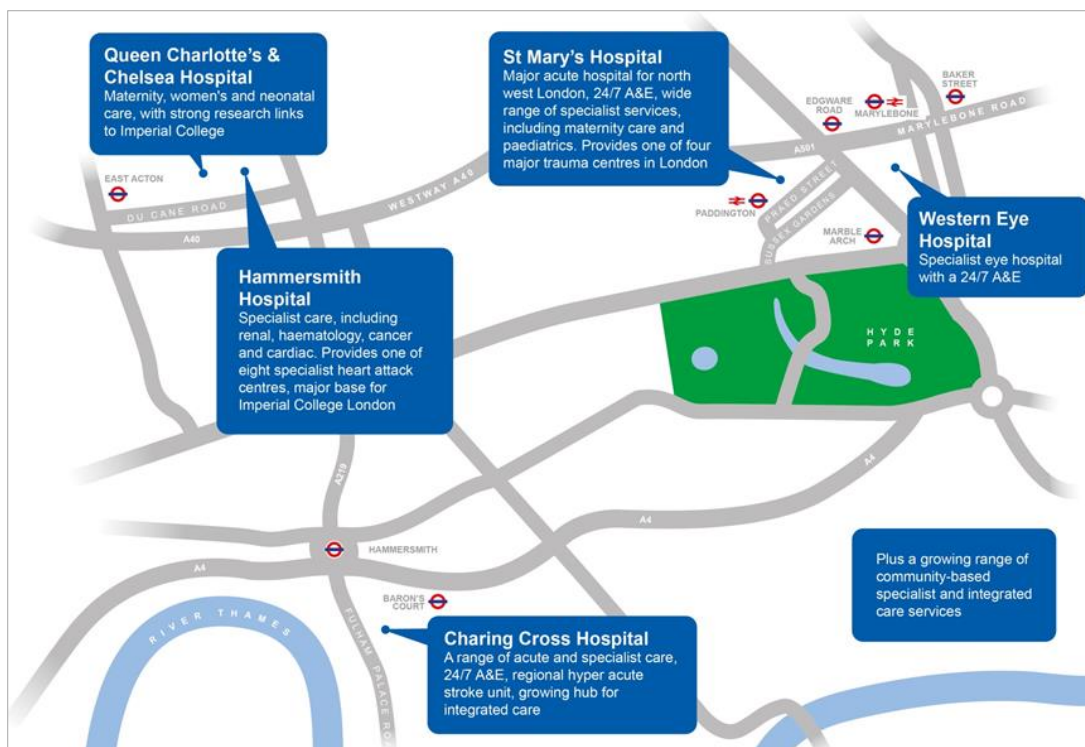


Figure 1 – Map of hospitals in Imperial College Healthcare NHS Trust

3. Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. The CQC works with NHS organisations like the Trust to make sure we provide people with safe, effective, compassionate and high-quality care.

Services are assessed according to the CQC's five domains: Safe; Effective; Caring; Responsive; and, Well-led.

Services are then rated. The categories for ratings are: Inadequate; Requires improvement; Good; and, Outstanding.

These ratings are then added up to produce an overall rating for each hospital, as well as a rating for the Trust overall.

4. Latest CQC inspection report

The latest CQC report on the Trust was published on 21 February 2018 and incorporates findings and ratings from several recent inspections:

- Core service inspections took place in November 2017 for surgery at Charing Cross, Hammersmith and St Mary's hospitals and for urgent and emergency services at Charing Cross and St Mary's hospitals. These core services were previously inspected in September 2014
- The CQC has introduced a new type of inspection to look at performance against the Well-led domain at Trust level. The Trust had its first of these inspections in December 2017.

Commenting on the CQC report, England's Chief Inspector of Hospitals, Professor Ted Baker, said:

“There has been some improvement in care at Imperial College Healthcare NHS Trust and the quality of some services are outstanding. However, there is still plenty of scope for the ratings of the Trust to improve.

“I hope that before future inspections the trust can make further improvements so that it can achieve an overall rating of Good rather than Requires Improvement.”

Link to [CQC summary report](#).

5. Summary of CQC inspection report

The overall Trust ratings have remained the same for all CQC ‘domains’ (Safe, Effective, Caring, Responsive and Well-led). The overall rating for the Trust also remains unchanged, at ‘Requires improvement’.

Our analysis of progress against each of the CQC domains for each of the core services across all of our hospitals does show we are moving in the right direction since our first inspection in 2014. For the Trust there are total of 67 ratings for the five CQC domains, and overall, for the core services inspected between November 2016 and November 2017:

- The Trust has no ‘Inadequate’ ratings
- Out of the total 67 ratings:
 - The Trust has improved in 20 ratings
 - Two of the ratings are ‘Outstanding’
 - Nine ratings have gone down
 - 38 ratings have remained the same:
 - 19 ratings are ‘Good’
 - 19 ratings are ‘Requires improvement’

Overall ratings for services at each site that were inspected are as follows:

- Charing Cross Hospital (surgery) – ‘Requires improvement’, the same rating as 2014
- Charing Cross Hospital (urgent and emergency services) – ‘Requires improvement’, down from ‘Good’ in 2014
- Hammersmith Hospital (surgery) – ‘Good’, an improvement since the 2014 inspection
- St Mary’s Hospital (urgent and emergency services) – ‘Requires improvement’, the same rating as 2014
- St Mary’s Hospital (surgery) – ‘Requires improvement’, the same rating as 2014.

The Trust was rated ‘Requires improvement’ in its first Trust level Well-led inspection.

Areas of outstanding practice noted by the CQC include:

- Our role as a leader in developing and using digital technology to improve patient care as a global digital exemplar
- Being part of the ‘Redthread’ youth violence intervention programme, which ensures seven-day support from an onsite youth worker at St Mary’s Hospital
- The major trauma centre within St Mary’s achieving good clinical outcomes for patients, recognised in the Trauma Audit & Research Network (TARN) audit

- Having a dedicated full-time play specialist working in the paediatric A&E at St Mary's Hospital to support children in the department
- Significant research funding in place to drive forward innovative practice in surgery. This included a recent breath test trial for oesophageal cancer diagnosis
- A surgery team being awarded a British Medical Journal (BMJ) prize in recognition of an innovative 'prepare for surgery' project that aimed to reduce the length of hospital stays
- The hepato-biliary service providing a specialised tertiary service for procedures such as 'Whipples' surgery for pancreatic cancer. Nurses on the hepato-biliary ward had developed specialist knowledge and skills to care for patients with complex symptoms
- The Northwest London RAPID (rapid access prostate imaging and diagnosis) pathway for prostate cancer where patients can have all their diagnostic imaging and biopsies carried out on the same day, shortening their number of hospital visits and the length of time they wait for a diagnosis
- Providing rapid access to cardiac catheterisation for patients with chest pain.

A number of the areas identified for improvement by the CQC are well documented challenges for the Trust that we are continuing to work hard to address – they include meeting the national standards for 4-hour Accident & Emergency access and 18-week wait for referral to treatment, reducing vacancy levels in key areas and improving the physical state of our facilities. There are also some specific improvements we must make, notably:

- Providing better assurance on how we are monitoring our performance effectively against agreed standards in the emergency department at St Mary's Hospital
- Improving the physical standards of some of our operating theatres at St Mary's Hospital in relation to rust and damage of fixtures
- Ensuring that equipment is regularly serviced, labelled to indicate the next review date, and appropriately stored in urgent and emergency services at both Charing Cross and St Mary's hospitals
- Improving our medicines management in urgent and emergency services at Charing Cross Hospital
- Increasing uptake for mandatory training among medical staff in surgery at St Mary's Hospital.

6. Next steps

The winter period is a particularly challenging time for the Trust, as it is for all acute healthcare providers, and we've seen unprecedented levels of activity over recent months, most keenly felt in our A&E departments. We know that there a number of key areas for improvement at both of our A&E departments at Charing Cross and St Mary's hospitals, with space and environment constraints exacerbating our capacity pressures. We've just completed a refurbishment and expansion of St Mary's A&E and we are planning a significant investment in Charing Cross A&E for the coming year – both of which we expect will make a positive difference for our patients and staff.

More generally, the CQC has acknowledged throughout the report the impact of our old estate and lack of space on the care and experience we can provide to patients. Progressing our redevelopment and estates improvement plans is a major priority for us in the coming year.

In terms of our Well-led inspection, the CQC said that our Trust Board has the right skills, knowledge and experience to lead the organisation in the delivery of its aims. We have been developing our leadership structures and systems over the past two years and we will continue to work hard to help all staff feel enabled and empowered to make improvements for the benefit of patient care.

Work is already underway to address the actions and we are considering our wider approach to improving our CQC ratings.

Our Trust Board considers regular update reports on CQC-related activity at and/or impacting the Trust at its public meetings.

Imperial College Healthcare NHS Trust

Inspection report

The Bays, South Wharf Road
St Mary's Hospital
London
W2 1NY

Tel: 02033113311
www.imperial.nhs.uk

7th November
28/02/2018

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?	Requires improvement 
Are services effective?	Good 
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

Imperial College Healthcare NHS Trust was formed on October 1, 2007 by merging St Mary's NHS Trust and Hammersmith Hospitals NHS Trust and integrating with the faculty of medicine at Imperial College London.

The trust has 12 registered locations and employs almost, 11,000 staff. The registered locations are:

- Queen Charlottes and Chelsea Hospital
- Western Eye Hospital
- Hammersmith Hospitals
- Northwick Park Renal Centre
- Ealing Renal Satellite Unit
- St Charles and Hammersmith Renal Centres
- West Middlesex Renal Centre
- Brent Renal Centre
- Charing Cross Hospital
- St Mary's Hospital
- Hayes Renal Centre
- Watford Renal Centre

The trust has an estimated range of population served is between 1,500,000 and 2,000,000 people.

The trust has a total of 1,412 inpatient beds spread across various locations:

- 733 Medical beds
- 302 Surgical beds
- 70 Children's beds
- 140 Maternity beds
- 136 Critical Care beds
- No dedicated End of Life Care beds

Overall summary

Our rating of this service stayed the same since our last inspection. We rated it as requires improvement.

What this trust does

In 2017, the trust provided a broad range of services across three acute hospitals, two specialist hospitals and seven renal centres. The trust is registered for the following registered activities;

- Treatment of disease, disorder or injury
- Surgical procedures

Summary of findings

- Diagnostic and screening procedures
- Maternity and midwifery
- Termination of pregnancy
- Family planning
- Assessment or medical treatment for persons detained under the 1983 Mental Health Act
- Management of supply of blood and blood derived products

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.

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 7 November and 9 November, we inspected two of the nine core services provided by the trust. We inspected Urgent and emergency services at St Mary's Hospital and Charing Cross Hospital, and Surgery at St Mary's Hospital Charing Cross Hospital and Hammersmith Hospital.

We carried out further unannounced visits to the two core services on the 20 November and 23 November.

We inspected Urgent and emergency care because we rated the service as requires improvement at one location during our last inspection in December 2014

We inspected Surgical services because we rated the service as requires improvement during our last inspection in December 2014.

We did not inspect Outpatients, diagnostics as this service was inspected in November 2016, and we had no new concerns about the safety and quality of the service.

We did not inspect Maternity as this service was inspected in May 2017 and we had no new concerns about the safety and quality of the service.

We did not inspect Medicine as this service was inspected in May 2017 and we had no new concerns about the safety and quality of the service.

We did not inspect Critical care, End of life care and services for Children and young people because the information we reviewed about the services indicated no change in the safety and quality of these services.

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 for the trust overall. What we found is summarised in the section headed 'Is this organisation well-led?'

Summary of findings

What we found

Overall trust

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

- We rated safe and responsive as requires improvement and effective and caring as good.
- We rated well-led for the trust overall as requires improvement.
- The ratings for each of the key questions remained the same.
- The ratings for each of the trust's acute locations remained the same.
- Our decisions on overall ratings take into account, for example, the relative size of services and we use our professional judgement to reach a fair and balanced rating.

St Mary's Hospital

- Our rating of St Mary's Hospital stayed the same. We rated it as requires improvement because safe, responsive and well-led require improvement and effective and caring were good.
- The hospital improved its rating of well-led since the last inspection, but the ratings for each of the other key questions remained the same.
- We inspected Urgent and emergency care during this inspection to check if improvements had been made. Our rating of the service stayed the same. We rated it as requires improvement because safe, effective, caring, responsive and well-led required improvement. The rating for well-led improved but the ratings for each of the other key questions remained the same.
- We inspected Surgery during this inspection to check if improvements had been made. Our rating of the service stayed the same. We rated it as requires improvement because safe and responsive required improvement and effective, caring and well-led were good. The rating for well-led improved but the ratings for each of the other key questions remained the same.
- We inspected the Medical care (including older people's care) service in October 2017 because we had concerns about the quality of the service. Our rating of the service stayed the same. We rated it as requires improvement because safe and responsive required improvement, and caring and well-led were good. The ratings for each of the key questions remained the same.
- We inspected the Maternity service in October 2017 because we had concerns about the quality of the service. Our rating of the service went down. We rated it as requires improvement because safe, responsive and well-led required improvement, and effective and caring were good. The ratings for safe, responsive and well-led went down and the ratings for each of the other key questions remained the same.
- We inspected the Outpatients and diagnostic imaging service in May 2017 to check if improvements had been made. Our rating of the service significantly improved. We rated it as good because safe, caring and well-led were good and responsive required improvement. We did not rate effective. The rating for responsive improved and the rating for well-led significantly improved. The ratings for each of the other key questions remained the same.

Charing Cross Hospital

- Our rating of Charing Cross Hospital stayed the same. We rated it as requires improvement because safe, responsive and well-led require improvement and effective and caring were good.
- The hospital improved its rating of effective since the last inspection, but the ratings for each of the other key questions remained the same.

Summary of findings

- We inspected Urgent and emergency care during this inspection to check if improvements had been made. Our rating of the service went down. We rated it as requires improvement because safe, effective, responsive and well-led required improvement, and caring was good. The rating for safe, responsive and well-led went down, and the ratings for each of the other key questions remained the same.
- We inspected Surgery during this inspection to check if improvements had been made. Our rating of the service stayed the same. We rated it as requires improvement because safe and responsive required improvement, and effective, caring and well-led were good. The rating for well-led improved and the ratings for each of the other key questions remained the same.
- We inspected the Medical care (including older people's care) service in October 2017 because we had concerns about the quality of the service. Our rating of the service improved. We rated it as good because safe and responsive required improvement; well-led was good, and caring and effective were outstanding. The ratings for effective, caring and well-led improved and the ratings for each of the other key questions remained the same.
- We inspected the Outpatients and diagnostic imaging service in May 2017 to check if improvements had been made. Our rating of the service improved. We rated it as requires improvement because safe, responsive and well-led were required improvement, and caring was good. The ratings for responsive and well-led improved; the rating for safe went down. We did not rate effective.

Hammersmith Hospital

- Our rating of Hammersmith Hospital stayed the same. We rated it as requires improvement because safe, responsive and well-led require improvement and effective and caring were good.
- The ratings for each of the key questions remained the same since our last inspection.
- We inspected Surgery during this inspection to check if improvements had been made. Our rating of the service improved. We rated it as good because effective, caring, responsive and well-led were good, and safe required improvement. The rating for responsive and well-led improved and the ratings for each of the other key questions remained the same.
- We inspected the Medical care (including older people's care) service in October 2017 because we had concerns about the quality of the service. Our rating of the service stayed the same. We rated it as requires improvement because safe and responsive required improvement, and effective, caring and well-led were good, the rating for well-led improved and the ratings for each of the other key questions remained the same.
- We inspected the Outpatients and diagnostic imaging service in May 2017 to check if improvements had been made. Our rating of the service significantly improved. We rated it as good because safe, caring and well-led were good and responsive required improvement. The ratings for responsive improved and the rating for well-led significantly improved; the rating for safe went down. We did not rate effective.

Are services safe?

Our rating of safe stayed the same. We took into account the current ratings of services not inspected this time. We rated safe as requires improvement because:

- The trust did not always assess risks to the safety of patients in a timely way to support them to stay safe. For example, in the ED, the trust was not meeting national standards for median time from arrival to initial assessment or treatment.
- The trust did not always have 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. There were high vacancy rates in some service areas.

Summary of findings

- The trust provided mandatory training in key skills to all staff, but rates of completion were below the trust's target.
- Medicines were not consistently prescribed, given, recorded and stored well.
- In some areas, the premises and equipment were unsuitable. For example, seven theatres at St Mary's hospital were in a poor state of repair and presented significant infection control risks to patients. Infection control and environmental control strategies in these areas were insufficient to address the risks.
- The trust was taking action to improve the management of patient safety incidents. 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.

However:

- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- The service planned for emergencies and staff understood their roles if one should happen.
- 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.

Are services effective?

Our rating of effective improved. We took into account the current ratings of services not inspected this time. We rated effective 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.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- 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 gave patients enough food and drink to meet their needs and improve their health.

However:

- The department were performing below the national average in many of the Royal College of Emergency Medicine (RCEM) audits.

Are services caring?

Our rating of caring stayed the same. We took into account the current ratings of services not inspected this time. 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.

Summary of findings

However:

- In Urgent and emergency services we found capacity issues and space limitations impacted on the ability of staff to provide care in a way that maintained the privacy and dignity of patients. Sensitive conversations were easily overheard when patients were nursed on trolleys in the corridor. We witnessed that no screens or barriers were used when examination was taking place on these patients. Cubicles within the majors department at St Mary's Hospital were too small to allow direct transfer hoist transfers, or trolley to bed transfers using patient transfer slides, so patients had to be moved out to the corridor space in order to do this

Are services responsive?

Our rating of responsive stayed the same. We took into account the current ratings of services not inspected this time. We rated responsive as requires improvement because:

- Services were not consistently planned and provided in a way that met the needs of local people.
- People could not be assured of being able to access services in a timely way. Arrangements to assess, admit, treat and discharge patients did not meet national standards.
- The trust consistently did not meet national targets for waiting times.

However:

- The trust 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.

Ratings tables

The ratings tables 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 the surgical service and the urgent and emergency care service.

For more information, see the Outstanding practice section in this report.

Areas for improvement

We found areas for improvement including three breaches of legal requirements that the trust must put right.

We also found a number of things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve the quality of services.

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

Action we have taken

We issued a requirement notice to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Summary of findings

Our action related to breaches of legal requirements in Urgent and emergency services and Surgery services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

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.

Outstanding practice

In Well-led:

- The trust's role as a leader in the adoption of digital technologies to improve patient care was recognised in March 2017 when, in partnership with a neighbouring NHS Foundation Trust, the trust was selected by NHS England to be one of 16 global digital exemplars in acute care. As a global digital exemplar, the trust receives funding and support to drive forward the use of digital technology and create products and approaches that can be used by other organisations.

In Urgent and emergency care:

St Mary's Hospital

- The major trauma centre within the department achieved good outcomes in the Trauma Audit & Research Network (TARN) audit. The trauma department was part of the 'Redthread' youth violence intervention programme, which ensured seven-day support from a youth worker embedded in the hospital. Any practitioner could refer a child or young person brought into department where there was a suspicion of violence, assault and/or exploitation as their index admission reason. As a major trauma centre for patients with gunshots or stab wounds, the hospital had developed a new patient pathway based on military medical techniques. Staff were undergoing teaching, scenarios and desktop exercises designed to help them deal with major trauma and incidents more effectively.
- A dedicated full-time play specialist worked in the ED to support children whilst receiving treatment. Volunteers were well placed in the paediatric ED waiting area helping to supervise and play with the children whilst they waited to be seen.

In Surgery:

- The division planned to implement a lead matron for mental health to ensure patients with rehabilitation needs following trauma were fully supported.
- A surgery team had been awarded a British Medical Journal prize in recognition of an innovative 'prepare for surgery' project that aimed to reduce the length of hospital stays. The programme aimed to improve multidisciplinary input from psychology, nutrition and exercise prior to surgery.
- The surgery division was research active and was awarded significant research funding each year that staff used to drive forward innovative practice. This included a recent breath test trial for oesophageal cancer diagnosis.

St Mary's Hospital

- The WLIP was based on the trust's recognition that a key need for the future was sustainability of services.
- The QI team worked with the Royal Academy of Arts to support staff that had innovative ideas for improvement and development to be able to design and implement these in a dedicated environment.

Summary of findings

- Staff who worked in link roles spoke positively of their work, which included continually improving services and training. For example, a healthcare assistant in Charles Pannett ward was part of a link team for improving nursing handovers. This team had submitted a new handover briefing sheet to the senior ward team for consideration.
- The Trust's PREPARE for surgery programme was designed to improve patients' condition undergoing surgery. It looked at different factors to focus on before and after a procedure, including physical activity, diet, psychological wellbeing and medication management. The PREPARE for surgery team had been named Patient Partnership and Surgical Team of the Year at the British Medical Journal (BMJ) Awards 2017.

Charing Cross Hospital

- The Northwest London RAPID (Rapid Access Prostate Imaging and Diagnosis) pathway for prostate cancer streamlined prostate cancer diagnostics. Multiple visits to obtain a diagnosis were reduced to one in which all diagnostic imaging and biopsies were carried out on the same day. This evidence-based service offered one-stop magnet resonance-imaging and diagnostic biopsy pathway for prostate cancer and resulted in significantly fewer men requiring biopsy.

Hammersmith Hospital

- The chest pain pathway provided rapid access via the heart attack centre to cardiac catheterisation including trans aortic valve replacement (TAVI), a relatively new technique pioneered at the Hammersmith. The pathway also provided patients with access to cardiac surgery. Cardiac services were being consolidated on the Hammersmith site to provide a specialist cardiac service. New roles such as advanced nurse practitioners had been developed to support implementation of the pathway to provide specialist skills.
- The hepato-biliary service provided a specialised tertiary service for procedures such as 'Whipples' surgery for pancreatic cancer. Nurses on the hepato-biliary ward had developed specialist knowledge and skills to care for patients with complex symptoms.

Areas for improvement

Actions 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.

Action the trust **MUST** take to improve:

In Urgent and emergency care:

St Mary's Hospital

- The trust must ensure that they are monitoring performance effectively against agreed standards.
- The trust must ensure that all portable equipment is regularly serviced and labelled to indicate the next review date.

Charing Cross Hospital

- The trust must ensure that control drugs cupboard key is kept securely and access is appropriately restricted.
- The trust must ensure that there are effective checking systems for airway trolleys and emergency medicines stored in the resuscitation bays.
- The trust must ensure that IV fluids are stored appropriately.
- The trust must ensure that all portable equipment is regularly serviced and labelled to indicate the next review date.

Summary of findings

In Surgery:

St Mary's Hospital

- The trust must address the low levels of completion of mandatory training amongst medical staff.
- The trust must address areas of non-compliance with AfPP guidance in relation to the disposal and management of hazardous and clinical waste.
- The trust must address the poor state of repair of theatres one to seven with urgent consideration of rust and damage to fixtures.
- The trust must implement processes to ensure that both daily and periodic cleaning meets trust standards, including effective monitoring and checklists.
- The trust must implement appropriate deep cleaning schedules for theatres.

Action the trust SHOULD take to improve

We told the trust that it should take action either to comply with minor breaches that did not justify regulatory action, to avoid breaching a legal requirement in future, or to improve services.

In Well-led:

- The trust should ensure it continually improves the quality of its services and safeguards high standards of care.
- The trust should improve systems for board oversight of risk to ensure identified risks are eliminated or reduced.
- The trust should ensure progress is made with the patient and public involvement (PPI) strategy to promote engagement.
- The trust should review and improve their performance for people with characteristics protected by the Equality Act 2010.

In Urgent and emergency care:

St Mary's Hospital

- The trust should ensure that all staff are up to date with their mandatory training.
- The trust should continue to audit hand hygiene and work to improve this.
- The trust should continue to work towards improving flow and capacity within the ED to improve time to initial assessment and treatment.
- The trust should ensure that appropriate risk assessments are completed in the clinical decisions unit (CDU).
- The trust should continue to proactively manage recruitment and retention of nursing staff.
- The trust should consider whether numbers of registered mental health nurses (RMNs) in ED are sufficient to keep vulnerable patients safe.
- The trust should ensure that the paediatric ED meets the London Quality Standards for paediatric consultant cover.
- The trust should consider how to improve IT systems across the department to enable easier sharing of information.
- The trust should ensure that all patients have their allergy status documented on all medication records.
- The trust should ensure that all patients receive timely pain relief and that this is documented in their records.

Summary of findings

- The trust should further investigate why the trust's unplanned re-attendance rate to ED within seven days was generally worse than both the national standard and the England average, and work to improve this.
- The trust should ensure that all staff receive an annual appraisal.
- The trust should provide training to all staff on treating patients with mental health conditions.
- The trust should ensure that all capacity assessments are fully documented.
- The trust should ensure that capacity issues and space limitations do not affect the privacy and dignity of patients.
- The trust should continue to consider how to improve low response rates in the NHS friends and family test (FFT) in the adult ED.
- The trust should consider how to inform patients of anticipated delays to treatment.
- The trust should improve the signage leading to the ED from the ground floor.
- The trust should continue to work towards improving the environment and capacity issues identified within the department.
- The trust should continue to work towards improving their performance in relation to arrival to receiving treatment, four hour performance, total time in ED and patients leaving without being seen.
- The trust should ensure patient information leaflets are available in the adult ED department.
- The trust should ensure that they are proactive in their risk assessments and that the risk register reflects all the risks within the department.

Charing Cross Hospital

- The trust should ensure that staff are compliant with hand hygiene practice and 'bare below the elbow' policy.
- The trust should ensure that paper records are stored securely.
- The trust should ensure that all staff are up to date with their mandatory training.
- The trust should continue to work towards improving flow and capacity within the ED to improve time to initial assessment and treatment.
- The trust should ensure that appropriate fall risk assessments are completed in the ED.
- The trust should ensure that the ED meets the RCEM Standard for 16 hours consultant cover.
- The trust should ensure that all staff in ED receives an annual appraisal.
- The trust should ensure that IV fluids are stored appropriately.
- The trust should ensure that second exit for secure room is not blocked and staff are aware of how to use that door.
- The trust should ensure that capacity issues and space limitations do not affect the privacy and dignity of patients.
- The trust should continue to work towards improving the environment and capacity issues identified within the department.
- The trust should continue to work towards improving their performance in relation to arrival to receiving treatment, four hour performance, total time in ED and patients leaving without being seen.
- The trust should ensure patient information leaflets and PALS leaflet are available in the ED.

Summary of findings

- The trust should ensure that they are proactive in their risk assessments and that the risk register reflects all the risks within the department.
- The trust should ensure there are effective systems for staff to escalated problems in a timely manner to the directorate level leaders.

In Surgery:

St Mary's Hospital

- The trust should continue to work towards sustained and consistent improvement in the use of the World Health Organisation safer surgery checklists.
- The trust should consider implementing dedicated competency training for staff in the pre-operative unit.
- The trust should review access and flow pathways to reduce the risk of patients spending extended periods in theatre recovery.

Charing Cross Hospital

- The trust should ensure that staff has received up-to-date training in all safety systems.
- The trust should continue to address high vacancy rates for nursing staff on the wards.
- The trust should ensure that all equipment is appropriately secured or in date for safety testing.
- The trust should address inconsistent performance for all five steps of the World Health Organisation safer surgery checklist.
- The trust should take measures to improve performance for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre as published in the 2016 National Emergency Laparotomy Audit.
- The service should ensure that patients waiting for surgery are better informed about their schedule.
- The trust should continue to address long waiting times for elective surgery admissions. The hospital did not meet national targets for any surgery waiting lists and continued to experience significant numbers of 18 week and 52 week breaches in referral to treatment times.
- The trust should investigate and improve average length of stay for patients in urology and ENT, which was higher than national average.
- The trust should investigate and improve a higher expected risk of readmission for elective admissions when compared to the England average.
- The trust should aim to decrease the number of patients whose operation is cancelled and are not treated within 28 days.
- The trust should investigate and take measures to address staff survey results that showed that less than half of respondents agreed that poor behaviour and performance was addressed effectively, also only slightly more than half thought senior leaders were visible and approachable.

Hammersmith Hospital

- The trust should ensure that Mandatory training compliance rates for staff improve.
- The trust should address inconsistent performance for all five steps of the World Health Organisation safer surgery checklist.

Summary of findings

- The trust should ensure there is adequate preparation and provision for emergency surgical cases at Hammersmith Hospital.

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.

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

- We found limited improvement of ratings of the trust's services. The rating of St Mary's Hospital, Charing Cross Hospital, Hammersmith Hospital and the trust overall required improved, which remained the same as at the last inspection.
- Although the trust had structures, systems and processes in place to support the delivery of its strategy, including sub-board committees, divisional committees and team meetings this had not resulted in achieving significant improvement in the services provided to patients.
- The trust had taken action to improve systems to identify learning from incidents and make improvements however, this was not yet fully embedded and there was limited evidence of sustained improvement.
- Although trust wanted to support a positive culture that supported and valued staff, there were limited staff networks in place promoting the diversity of staff. A Lesbian, Gay, Bi-sexual and Trans (LGBT) staff network was being established at the time of our inspection. There were no staff groups to support BME, religion, disability networks. There was variable evidence about how staff felt equality and diversity were promoted in their day to day work and when looking at opportunities for career progression.
- The trust has made limited progress with its patient and public involvement (PPI) strategy to engage with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. The strategy is not fully embedded or implanted; the executive acknowledge there is not a fully shared view across the whole trust of the relative value and risks.

However:

- The trust board had the appropriate range of skills, knowledge and experience to perform its role. The trust board members were a group of individuals with a wide range of experience, knowledge and skills, who had joined the board at a variety of dates from 2012 to 2017. They comprised seven non-executive directors, including the chairperson and four executives: chief executive, medical director, director of nursing (in post since 2008) and chief financial officer (in post since August 2015). The trust also had managers at all levels with the right skills and abilities to run the service.
- The trust collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards.
- The trust had a vision, strategy for the future and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- The trust had a clinical audit programme incorporating expected national and local clinical audit studies. The trust was committed to research and innovation.

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
Requires improvement ↔ Feb 2018	Good ↔ Feb 2018	Good ↔ Feb 2018	Requires improvement ↔ Feb 2018	Requires improvement ↔ Feb 2018	Requires improvement ↔ Feb 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
St Mary's Hospital	Requires improvement →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Requires improvement →← Feb 2018	Requires improvement ↑ Feb 2018	Requires improvement →← Feb 2018
Charing Cross Hospital	Requires improvement →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Requires improvement →← Feb 2018	Requires improvement →← Feb 2018	Requires improvement →← Feb 2018
Hammersmith Hospital	Requires improvement →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Requires improvement →← Feb 2018	Requires improvement →← Feb 2018	Requires improvement →← Feb 2018
Queen Charlotte's and Chelsea Hospital	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Requires improvement Dec 2014	Good Dec 2014
Western Eye Hospital	N/A	N/A	N/A	N/A	N/A	N/A
Overall trust	Requires improvement →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Requires improvement →← Feb 2018	Requires improvement →← Feb 2018	Requires improvement →← Feb 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 St Mary's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↔ Feb 2018	Requires improvement ↔ Feb 2018	Requires improvement ↔ Feb 2018	Requires improvement ↔ Feb 2018	Requires improvement ↑ Feb 2018	Requires improvement ↔ Feb 2018
Medical care (including older people's care)	Requires improvement ↔ Oct 2017	Good ↔ Oct 2017	Good ↔ Oct 2017	Requires improvement ↔ Oct 2017	Good ↔ Oct 2017	Requires improvement ↔ Oct 2017
Surgery	Requires improvement ↔ Feb 2018	Good ↔ Feb 2018	Good ↔ Feb 2018	Requires improvement ↔ Feb 2018	Good ↑ Feb 2018	Requires improvement ↔ Feb 2018
Critical care	Good Dec 2014	Good Dec 2014	Good Dec 2014	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014
Maternity	Requires improvement ↓ Oct 2017	Good ↔ Oct 2017	Good ↔ Oct 2017	Requires improvement ↓ Oct 2017	Requires improvement ↓ Oct 2017	Requires improvement ↓ Oct 2017
Services for children and young people	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
End of life care	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Outpatients and diagnostic imaging	Good ↔ May 2017	N/A	Good ↔ May 2017	Requires improvement ↑ May 2017	Good ↑↑ May 2017	Good ↑↑ May 2017
Overall*	Requires improvement ↔ Feb 2018	Good ↔ Feb 2018	Good ↔ Feb 2018	Requires improvement ↔ Feb 2018	Requires improvement ↑ Feb 2018	Requires improvement ↔ Feb 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 Charing Cross Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↓ Feb 2018	Requires improvement Feb 2018	Good ↔ Feb 2018	Requires improvement ↓ Feb 2018	Requires improvement ↓ Feb 2018	Requires improvement ↓ Feb 2018
Medical care (including older people's care)	Requires improvement ↔ Oct 2017	Outstanding ↑ Oct 2017	Outstanding ↑ Oct 2017	Requires improvement ↔ Oct 2017	Good ↑ Oct 2017	Good ↑ Oct 2017
Surgery	Requires improvement ↔ Feb 2018	Good ↔ Feb 2018	Good ↔ Feb 2018	Requires improvement ↔ Feb 2018	Good ↑ Feb 2018	Requires improvement ↔ Feb 2018
Critical care	Requires improvement Dec 2014	N/A	Good Dec 2014	Requires improvement Dec 2014	Requires improvement Dec 2014	Requires improvement Dec 2014
End of life care	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Outpatients and diagnostic imaging	Requires improvement ↓ May 2017	N/A	Good ↔ May 2017	Requires improvement ↑ May 2017	Requires improvement ↑ May 2017	Requires improvement ↑ May 2017
Overall*	Requires improvement ↔ Feb 2018	Good ↔ Feb 2018	Good ↔ Feb 2018	Requires improvement ↔ Feb 2018	Requires improvement ↔ Feb 2018	Requires improvement ↔ Feb 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 Hammersmith Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement ↔ Oct 2017	Good ↔ Oct 2017	Good ↔ Oct 2017	Requires improvement ↔ Oct 2017	Good ↑ Oct 2017	Requires improvement ↔ Oct 2017
Surgery	Requires improvement ↔ Feb 2018	Good ↔ Feb 2018	Good ↔ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018
Critical care	Requires improvement Dec 2014	N/A	Good Dec 2014	Requires improvement Dec 2014	Requires improvement Dec 2014	Requires improvement Dec 2014
Services for children and young people	Good Dec 2014	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014	Requires improvement Dec 2014	Requires improvement Dec 2014
End of life care	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Outpatients and diagnostic imaging	Good ↔ May 2017	N/A	Good ↔ May 2017	Requires improvement ↑ May 2017	Good ↑↑ May 2017	Good ↑↑ May 2017
Overall*	Requires improvement ↔ Feb 2018	Good ↔ Feb 2018	Good ↔ Feb 2018	Requires improvement ↔ Feb 2018	Requires improvement ↔ Feb 2018	Requires improvement ↔ Feb 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 Queen Charlotte's and Chelsea Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Neonatal services	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Requires improvement Dec 2014	Requires improvement Dec 2014
Overall*	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Requires improvement Dec 2014	Requires improvement Dec 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.

Hammersmith Hospital

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Key facts and figures

Imperial College Healthcare NHS Trust was formed on October 1, 2007 by merging St Mary's NHS Trust and Hammersmith Hospitals NHS Trust and integrating with the faculty of medicine at Imperial College London.

The trust has 12 registered locations and employs almost, 11,000 staff. The registered locations are:

- Queen Charlottes and Chelsea Hospital
- Western Eye Hospital
- Hammersmith Hospitals
- Northwick Park Renal Centre
- Ealing Renal Satellite Unit
- St Charles and Hammersmith Renal Centres
- West Middlesex Renal Centre
- Brent Renal Centre
- Charing Cross Hospital
- St Mary's Hospital
- Hayes Renal Centre
- Watford Renal Centre

The trust has an estimated range of population served is between 1,500,000 and 2,000,000 people.

The trust has a total of 1,412 inpatient beds spread across various locations:

- 733 Medical beds
- 302 Surgical beds
- 70 Children's beds
- 140 Maternity beds
- 136 Critical Care beds
- No dedicated End of Life Care beds

Summary of findings

Summary of services at Hammersmith Hospitals

Requires improvement → ←

Our rating of Hammersmith Hospital stayed the same. We rated it as requires improvement because safe, responsive and well-led require improvement and effective and caring were good.

- The ratings for each of the key questions remained the same since our last inspection.
- We inspected Surgery during this inspection to check if improvements had been made. Our rating of the service improved. We rated it as good because effective, caring, responsive and well-led were good, and safe required improvement. The rating for responsive and well-led improved and the ratings for each of the other key questions remained the same.
- We inspected the Medical care (including older people's care) service in October 2017 because we had concerns about the quality of the service. Our rating of the service stayed the same. We rated it as requires improvement because safe and responsive required improvement, and effective, caring and well-led were good, the rating for well-led improved and the ratings for each of the other key questions remained the same.
- We inspected the Outpatients and diagnostic imaging service in May 2017 to check if improvements had been made. Our rating of the service significantly improved. We rated it as good because safe, caring and well-led were good and responsive required improvement. The ratings for responsive improved and the rating for well-led significantly improved; the rating for safe went down. We did not rate effective.

Surgery

Good ● ↑

Key facts and figures

There are eight operating theatres used by all the surgical specialties based at Hammersmith hospital. The main surgical specialities are cardiac surgery, thoracic and hepato-biliary. Renal transplant also takes place on the site but was not included in this inspection. There are nine recovery beds where patients are monitored post-operatively before returning to the ward. There are five catheter labs adjacent to the heart attack centre. The catheter labs were open from 8am until 6pm Monday to Friday. One catheter lab was closed for upgrading. Additional lists were provided on Saturday mornings to reduce waiting times. There were nine recovery beds in the catheter lab for patients following the completion of their procedure.

There were 2360 spells of surgical treatment between June 2016 and May 2017. The vast majority of admissions are for surgery, which is planned. Approximately 15% of surgical admissions were emergencies.

The catheter labs carried out approximately 25 procedures per day

Summary of this service

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

- Managers monitored staffing levels and patients' needs daily.
- Staff knew what incidents to report and how to report them. Staff told us they knew about serious incidents and never events which occurred on site but were not always aware of incidents on other sites in the trust.
- A critical care outreach team responded to emergencies five days a week. There were plans to extend this to a seven day service
- Risk assessments were completed for patients on the surgical wards for falls, dehydration and pressure ulcers
- Surgical site infection rates were monitored. The monitoring showed the infection rate was consistently below the England average.
- Surgical services at Hammersmith Hospital held mortality and morbidity meetings to review adverse outcomes.
- Readmission rates for hepato-biliary surgery were lower than the England average. Cardiac and cardio-thoracic readmission rates were higher than the England average.
- Patients physical needs were assessed, and their care and treatment was delivered in line with evidence-based guidance.
- There was participation in local and national audits. Findings were used to improve care and treatment and patients' outcomes.
- Nursing staff used national early warning scores (NEWS) to assess and monitor a patient's condition and identify if they deteriorated. Staff provided care in line with the National Institute of Health and Care Excellence (NICE) Guideline (CG50) for deteriorating patients.
- Staff were qualified and had the skills required to carry out their roles effectively. Staff's training needs were identified and training was provided. Staff were supported to maintain and develop their professional skills and experience.

Surgery

- Hepatobiliary and pancreatic surgery patients at Hammersmith Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
- There was good access to a specialist multi-disciplinary pain management team.
- Patients' needs were reviewed weekly by a multidisciplinary team to plan the care provided.
- The average length of stay for Hepatobiliary and pancreatic surgery elective patients at Hammersmith Hospital was 4.5 days lower than the England average of 5.8 days.
- The average length of stay for Cardiac Surgery elective patients at Hammersmith Hospital was 8.9 days, similar compared to the England average of 8.7 days.
- The average length of stay for Cardiac Surgery for non-elective patients at Hammersmith Hospital was 10.7 days, which is lower than the England average of 12.0 days.
- The cardiac preoperative assessment process was still being developed. High risk patients were assessed face to face two to three weeks prior to admission. Lower risk patients were assessed over the telephone.
- The Friends and Family Test response rate for Surgery at Imperial College Healthcare NHS Trust was 35%, which was better than the England average of 29% between August 2016 and July 2017. Hammersmith Hospital had the highest response rate of any site in the trust.
- Patients told us staff had involved relatives in discussions about their care and the support they would need after the procedure was completed.
- Patients who had difficulty travelling to the hospital were admitted the evening before to ensure they were ready for surgery the next day.
- Staff recognised how anxious and worried patients were and offered reassurance. Patients told us staff had been reassuring and recognised they were in pain and offered pain relief.
- Patients with complex needs were highlighted on the trust's clinical information system, which meant staff could consider any adjustments to their care, which might be required.
- Care of the elderly medical staff assessed older patients, with dementia, undergoing a cardiac procedure.
- Relatives were able to stay to support patients with special needs. Patients admitted via the heart attack centre were prioritised by the cardiac lab team in the morning. Patients with diabetes or other co-morbidities were prioritised.
- Palliative patients were identified at the weekly multidisciplinary meeting. The palliative care team supported patients to make informed choices about their care.
- Local leaders focused on quality and performance and developed plans for transforming the care provided on the Hammersmith site.
- Clinical leaders provided clear, strategic goals and demonstrated commitment to achieving service improvement. Local leaders were visible, approachable and supportive to staff.
- There was a strong governance framework to support the delivery of the strategy and good quality of care.
- There was a programme of clinical and internal audit used to monitor performance and safety which identified where improvements could be made.
- Processes for risk identification, recording and managing risks, issues and mitigating action were well managed. Recorded risks correlated with the risks highlighted by staff.
- There was a positive culture which had resulted in improved recruitment and retention.

Surgery

- Staff understood the plan for developing services and described how they were motivated to play a role in developing the service.
- Staff spoke positively about their managers in all the surgical specialities.

However:

- We were not assured there was a clear pathway for identifying patients at risk of sepsis.
- Although compliance with World Health Organisation safer surgery checklists had improved since the last inspection, audits showed inconsistent performance for all five steps.
- The service was using the five steps to safer surgery surgical checklist but had not developed more detailed local safety protocols – local safety standards for invasive procedures (LocSSIPs.)
- Controlled drugs brought into the hospital on admission were not always checked until the patient was being discharged which meant there was a risk that any missing medicines were only identified at the end of their stay.
- All patients at Hammersmith Hospital had a slightly higher expected risk of readmission for elective admissions when compared to the England average.
- Mandatory training rates did not meet the trust’s target of 90% but they were higher at the Hammersmith than Charing Cross and St Marys.
- Medical and dental staff did not achieve the trust target of 90% for any of the mandatory training modules
- The surgical debrief was not documented.
- One patient told us they were not impressed with the catering service. They said staff were embarrassed offering food they knew was culturally unacceptable. Following our inspection the trust provided further evidence, which showed they provided menus that met patients’ different cultural needs.
- Referral to treatment time for cardiothoracic surgery had improved but 78.8% of patients were referred for cardiothoracic treatment within 18 weeks compared to the England average of 84.4%.
- The operating department did not have a theatre reserved for emergencies

Is the service safe?

Requires improvement ● → ←

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

- We were not assured there was a clear pathway for identifying patients at risk of sepsis.
- Although compliance with World Health Organisation safer surgery checklists had improved since the last inspection, audits showed inconsistent performance for all five steps.
- The service was using the five steps to safer surgery surgical checklist but had not developed more detailed local safety protocols – local safety standards for invasive procedures (LocSSIPs.)
- Controlled drugs brought into the hospital on admission were not always checked until the patient was being discharged which meant there was a risk that any missing medicines were only identified at the end of their stay.
- All patients at Hammersmith Hospital had a slightly higher expected risk of readmission for elective admissions when compared to the England average.

Surgery

- Mandatory training rates did not meet the trust's target of 90% but they were higher at the Hammersmith than Charing Cross and St Marys.
- Medical and dental staff did not achieve the trust target of 90% for any of the mandatory training modules
- The surgical debrief was not documented.

However:

- Nursing staff used national early warning scores (NEWS) to assess and monitor a patient's condition and identify if they deteriorated. Staff provided care in line with the National Institute of Health and Care Excellence (NICE) Guideline (CG50) for deteriorating patients.
- Staff knew what incidents to report and how to report them. Staff told us they knew about serious incidents and never events that occurred on site but were not always aware of incidents on other sites in the trust.
- Risk assessments were completed for patients on the surgical wards for falls, dehydration and pressure ulcers
- Surgical site infection rates were monitored. The monitoring showed the infection rate was consistently below the England average.

Is the service effective?

Good   

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

- Patients' physical needs were assessed, and their care and treatment was delivered in line with evidence-based guidance.
- There was participation in local and national audits. Findings were used to improve care, treatment, and patients' outcomes.
- Staff were qualified and had the skills required to carry out their roles effectively. Staff's training needs were identified and training was provided. Staff were supported to maintain and develop their professional skills and experience.
- Hepatobiliary and pancreatic surgery patients at Hammersmith Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
- There was good access to a specialist multi-disciplinary pain management team.
- Patients' needs were reviewed weekly by a multidisciplinary team to plan the care provided.
- The average length of stay for Hepatobiliary and pancreatic surgery elective patients at Hammersmith Hospital was 4.5 days lower than the England average of 5.8 days.
- Readmission rates for hepato-biliary surgery were lower than the England average.
- The average length of stay for Cardiac Surgery elective patients at Hammersmith Hospital was 8.9 days, similar compared to the England average of 8.7 days.
- The average length of stay for Cardiac Surgery for non-elective patients at Hammersmith Hospital was 10.7 days, which is lower than the England average of 12.0 days.
- The cardiac preoperative assessment process was still being developed. High-risk patients were assessed face to face two to three weeks prior to admission. Lower risk patients were assessed over the telephone.

Surgery

However:

- Cardiac Surgery patients at Hammersmith Hospital had a much higher expected risk of readmission for elective admissions when compared to the England average.
- Thoracic Surgery patients at Hammersmith Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.
- The average length of stay for thoracic surgery elective patients at Hammersmith Hospital was 6.4 days; this was than the England average of 5.4 days.

Is the service caring?

Good   

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

- The Friends and Family Test response rate for Surgery at Imperial College Healthcare NHS Trust was 35%, which was better than the England average of 29% between August 2016 and July 2017. Hammersmith Hospital had the highest response rate of any site in the trust.
- Patients told us staff had involved relatives in discussions about their care and the support they would need after the procedure was completed.
- Patients who had difficulty travelling to the hospital were admitted the evening before to ensure they were ready for surgery the next day.
- Staff recognised how anxious and worried patients were and offered reassurance. Patients told us staff had been reassuring and recognised they were in pain and offered pain relief.

However:

- One patient told us they were not impressed with the catering service. They said staff were embarrassed offering food they knew was culturally unacceptable.

Is the service responsive?

Good  

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

- Referral to treatment times had improved for cardiothoracic surgery ranging from 84.62% to 91.45% for an incomplete pathway, over a 9 month period from April 2017, which was better than the national average.
- Patients with complex needs were highlighted on the trust's clinical information system, which meant staff could consider any adjustments to their care, which might be required.
- Care of the elderly medical staff assessed older patients, with dementia, undergoing a cardiac procedure.
- Relatives were able to stay to support patients with special needs. Patients admitted via the heart attack centre were prioritised by the cardiac lab team in the morning. Patients with diabetes or other co-morbidities were prioritised.
- Palliative patients were identified at the weekly multidisciplinary meeting. The palliative care team supported patients to make informed choices about their care.

Surgery

However:

- The operating department did not have a theatre reserved for emergencies.

Is the service well-led?

Good  

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

- Local leaders focused on quality and performance and developed plans for transforming the care provided on the Hammersmith site.
- Clinical leaders provided clear, strategic goals and demonstrated commitment to achieving service improvement. Local leaders were visible, approachable and supportive to staff.
- There was a strong governance framework to support the delivery of the strategy and good quality of care.
- There was a programme of clinical and internal audit used to monitor performance and safety that identified where improvements could be made.
- Processes for risk identification, recording and managing risks, issues and mitigating action were well managed. Recorded risks correlated with the risks highlighted by staff.
- There was a positive culture, which had resulted in improved recruitment and retention.
- Staff understood the plan for developing services and described how they were motivated to play a role in developing the service.
- Staff spoke positively about their managers in all the surgical specialities.

Outstanding practice

The chest pain pathway provided rapid access via the heart attack centre to cardiac catheterisation including trans-aortic valve replacement (TAVI), a relatively new technique pioneered at the Hammersmith. The pathway also provided patients with access to cardiac surgery. Cardiac services were being consolidated on the Hammersmith site to provide a specialist cardiac service with new roles such as advanced nurse practitioners being developed to support implementation of the pathway and to provide specialist skills.

The hepato-biliary service provided a specialised tertiary service for procedures such as ‘Whipples’ surgery for pancreatic cancer. Nurses on the hepato-biliary ward had developed specialist knowledge and skills to care for patients with complex symptoms.

Areas for improvement

Action the trust SHOULD take to improve:

- The trust should ensure that Mandatory training compliance rates for staff improve.
- The trust should address inconsistent performance for all five steps of the World Health Organisation safer surgery checklist.
- The trust should ensure there is adequate preparation and provision for emergency surgical cases at Hammersmith Hospital.

Charing Cross Hospital

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Tel: 02033113311
www.imperial.nhs.uk

Key facts and figures

Imperial College Healthcare NHS Trust was formed on October 1, 2007 by merging St Mary's NHS Trust and Hammersmith Hospitals NHS Trust and integrating with the faculty of medicine at Imperial College London.

The trust has 12 registered locations and employs almost, 11,000 staff. The registered locations are:

- Queen Charlottes and Chelsea Hospital
- Western Eye Hospital
- Hammersmith Hospitals
- Northwick Park Renal Centre
- Ealing Renal Satellite Unit
- St Charles and Hammersmith Renal Centres
- West Middlesex Renal Centre
- Brent Renal Centre
- Charing Cross Hospital
- St Mary's Hospital
- Hayes Renal Centre
- Watford Renal Centre

The trust has an estimated range of population served is between 1,500,000 and 2,000,000 people.

The trust has a total of 1,412 inpatient beds spread across various locations:

- 733 Medical beds
- 302 Surgical beds
- 70 Children's beds
- 140 Maternity beds
- 136 Critical Care beds

Summary of findings

- No dedicated End of Life Care beds

Summary of services at Charing Cross Hospital

Requires improvement ● → ←

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

- The hospital improved its rating of effective since the last inspection, but the ratings for each of the other key questions remained the same.
- We inspected Urgent and emergency care during this inspection to check if improvements had been made. Our rating of the service went down. We rated it as requires improvement because safe, effective, responsive and well-led required improvement, and caring was good. The rating for safe, responsive and well-led went down, and the ratings for each of the other key questions remained the same.
- We inspected Surgery during this inspection to check if improvements had been made. Our rating of the service stayed the same. We rated it as requires improvement because safe and responsive required improvement, and effective, caring and well-led were good. The rating for well-led improved and the ratings for each of the other key questions remained the same.
- We inspected the Medical care (including older people's care) service in October 2017 because we had concerns about the quality of the service. Our rating of the service improved. We rated it as good because safe and responsive required improvement; well-led was good, and caring and effective were outstanding. The ratings for effective, caring and well-led improved and the ratings for each of the other key questions remained the same.
- We inspected the Outpatients and diagnostic imaging service in May 2017 to check if improvements had been made. Our rating of the service improved. We rated it as requires improvement because safe, responsive and well-led were required improvement, and caring was good. The ratings for responsive and well-led improved; the rating for safe went down. We did not rate effective.

Urgent and emergency services

Requires improvement  

Key facts and figures

The urgent and emergency department (ED) at Charing Cross Hospital is open 24 hours a day, seven days a week. There is a five-bay resuscitation area, 12 cubicles for major's assessment and treatment and an 18-bedded clinical decision unit (CDU) and an ambulatory assessment area (AAU). Charing Cross Hospital (CXH) has a hyper-acute stroke unit (HASU) so stroke patients coming in by ambulance are often brought to the hospital. The department does not generally treat gynaecology or maternity patients or children. A few patients in these groups arrive independently and are stabilised before transfer to more appropriate hospital.

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

The UCC is a joint venture led by Imperial College NHS Trust working with the London Central & West Unscheduled Care Collaborative. The UCC is open 24 hours a day, seven days a week and led by GPs with support from emergency nurse practitioners (ENPs).

To come to our rating, we spoke with 52 members of staff, 21 patients and their relatives. We examined 16 sets of medical notes for patients treated in the department, 11 prescription charts and three sets of medical notes of patient with mental health condition. We also reviewed additional evidence submitted to us. We visited the department again unannounced on 20 November 2017.

Summary of this service

Our overall rating of this service went down. We rated it as requires improvement because:

- We observed that not all staff adhered to the infection control policy and did not consistently comply with hand hygiene practice and 'bare below the elbows' policy.
- The air-way trolleys were not checked regularly and we found out of date and loose single use items in one air way trolley.
- We were not assured of effective systems in place to check emergency medications and it was unclear how the department could ensure that checks were carried out daily at each shift.
- We found that in the clinical decision unit, CD cupboard keys were not held by a registered nurse and were kept in an open tray by the nursing station, which was against the medicine regulations.
- Junior clinical staff were inconsistent in sepsis six management. We observed two suspected cases of sepsis and in both cases, not all six initial indicators were assessed. None of the staff we spoke with had any specific sepsis training.
- Clinical staff in ED were inconsistent in their practice in recording falls risk assessment.
- We found that paper records were not stored securely in clinical decision unit and major's area.
- The department were performing below the national average in many of the Royal College of Emergency Medicine (RCEM) audits.
- Staff appraisal rates did not meet the trust target of 95%, falling considerably short of this in some groups of staff.

Urgent and emergency services

- General observations confirmed staff considered the privacy and dignity of patients. However, during busy period, capacity issues and space limitations affected the ability of staff to provide care which maintained the privacy and dignity of patients. Sensitive conversations were easily overheard when patients were nursed on trolleys in the corridor.
- The department's capacity issue along with its physical layout provided a challenging environment to staff. Five resuscitation bays were frequently used for seven to eight patients.
- The department was not meeting the needs of people with learning disability (LD) and no specific actions were taken by the department to address the needs of people with LD. Staff showed limited understanding of caring and meeting the needs of LD patients.
- The department was not proactive in their risk assessments and not all risks identified by us during the inspection were reflected on the risk register.
- During periods when the service was very busy we found that the leadership did not had the full understanding of the problems faced as staff were too busy looking after patients to inform leadership. We were not assured that the directorate level leaders had the full oversight of the problems faced by staff.

However:

- The urgent and emergency department at Charing Cross Hospital had a stable medical workforce. Between July 2016 and June 2017, the department reported, turnover rate of 0% and only 0.07% sickness rate.
- Staff were aware of the incident reporting procedures and how to raise any concerns, staff said they were encouraged to report incidents and received direct feedback from their line manager, clinical leads and in teaching sessions.
- We were assured that patient were receiving timely pain relief. We reviewed 16 sets of patient's notes, which showed pain relief was offered in all applicable cases and was followed up appropriately.
- We observed good multidisciplinary team working and positive interactions across all staff levels.
- During quieter periods, we observed compassionate care delivered by nurses and doctors. Staff engaged in an open and positive way with patients and their relatives.
- Most patients told us they felt informed about the treatment they would receive and the processes in the department.
- We found the needs of people living with dementia were being met.
- There was clear leadership structure for both medical and nursing staff. Local leadership team was described as visible and proactive by all clinical staff.

Is the service safe?

Requires improvement ● ↓

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

- At our last inspection, the department was not meeting the statutory and mandatory training level for staff. At this inspection, the training levels were still below the trust's minimum standard.
- The department failed to meet the trust target of 90% for all safeguarding modules.
- We observed that not all staff adhered to the infection control policy and did not consistently comply with hand hygiene practice and 'bare below the elbows' policy.

Urgent and emergency services

- Not all portable equipment we checked had been recently serviced and labelled to indicate the next review date.
- We found several chairs within the main waiting area and in the major's area with rips and exposed foam. One of the cupboards within the medicines storage room had exposed wood, which was not compliant with infection control guidelines.
- We found that in resuscitation area, intravenous (IV) fluids were stocked in open drawers. The drawers were not clean and had visible dirt in them and in one drawer; there were specks of dried blood. We also found specks of blood on top of the paediatric airway trolley.
- The airway trolleys were not checked regularly and we found out of date and loose single use items in one airway trolley.
- The second exit door for the secure room for mental health patient was blocked. Senior staff were unaware that the second exit was not accessible and some senior staff were uncertain about how to operate the second door. When we highlighted our concerns, we were assured that the corridor will be cleared out and the second exit will be made accessible and staff will be informed about operating the second exit door. However, during our unannounced visit in the evening, the corridor was still not in use and was cluttered with portable radiators and a bicycle; there was still a sign on the door not to use the exit.
- We found that in the clinical decision unit, CD cupboard keys were not held by a registered nurse and were kept in an open tray by the nursing station. This meant access was not appropriately restricted.
- We were not assured, if there were effective systems to check emergency medications and it was unclear how the department could ensure that these checks were carried out daily.
- We observed that flow of patients through streaming, was not handled in a timely and methodical way. Over the last year, only 46.1% of patients were streamed within 15 minutes of arrival and the hospital had not met this standard for any single month. The average time from arrival to completion of streaming at the hospital was 23 minutes.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet the standard for any of the months over the 12-month period between August 2016 and July 2017.
- Between April 2016 and September 2017, within 15 minutes ambulances hand over ranged 35% to 51%. We saw evidence of an ongoing action plan for continued monitoring and observed six handovers during our inspection and all were within 15 minutes.
- Between June 2016 and July 2017, the trust reported nine "black breaches", as detailed in the chart below. Out of nine, eight black breaches were at Charing Cross Hospital. Increase in activity was cited as the reason for the breaches and in most cases the trusts' full capacity protocol was triggered.
- Junior clinical staff were inconsistent in sepsis six management. We observed two suspected cases of sepsis and in both cases, not all six initial indicators were assessed. None of the staff we spoke with had any specific sepsis training.
- Clinical staff in ED were inconsistent in their practice in recording patients falls risk assessment. For example, at one point during our inspection, only one out of three patients within the department at risk of fall had their falls assessment completed.
- There was less than 16 hours of face-to-face consultant cover each day. Senior clinical staff were aware that it did not meet the London Quality Standards and this was on the directorate risk register.

Urgent and emergency services

- We found that paper records were stored in an open trolley by the nursing station in major's area. In the clinical decision unit, patients' records were also not kept securely to prevent the risk of unauthorised access to patient information. During unannounced inspection, we found a patient prescription was pinned on a notice board in the staff break room, we highlighted this to the senior clinical staff who removed it immediately and agreed that it should not have been there as it contained patient details.

However:

- The urgent and emergency department at Charing Cross Hospital had a stable medical workforce. Between July 2016 and June 2017, the department reported, 0% turnover rate of 0% and only 0.07% sickness rate. In October 2017, the department had an establishment of 29.69 WTE with 30.34 WTE in post, resulting in a vacancy rate of -2.19%. In November 2017, there was an establishment of 29.69 with 28.74 WTE in post, for a vacancy rate of 3.20%.
- Staff were aware of the incident reporting procedures and how to raise any concerns, staff said they were encouraged to report incidents and received direct feedback from their line manager, clinical leads and in teaching sessions. They gave us examples of incidents they had reported.
- All staff were fully aware of the duty of candour and were able to give examples of how they applied this requirement in practice
- Between July 2016 and August 2017, the trust reported no incidents classified as never events for Urgent and Emergency Care.

Is the service effective?

Requires improvement ●

We did not rate effective at our last inspection. We rated effective at this inspection as requires improvement because:

- The department were performing below the national average in many of the Royal College of Emergency Medicine (RCEM) audits.
- Though staff had access to relevant guidelines including paediatric guidance on the trust intranet. We found that an out-of-date (2010) paediatric resuscitation guideline was on display in the paediatric dedicated resuscitation bay.
- A range of evidence based clinical care pathways were available electronically and used for patients with relevant conditions. These included sepsis, stroke and frailty, amongst others. These pathways included prompts and treatment steps for staff to follow. However, we observed two cases of suspected sepsis and found the care was inconsistent and not in line with the sepsis guideline.
- In the CQC ED Survey 2016, the trust scored 5.2 for the question "Were you able to get suitable food or drinks when you were in the ED? This was worse than other trusts. We observed that comfort rounds were not at regular intervals, staff were doing these rounds on an adhoc basis, with limited equipment to serve food.
- Between August 2016 and July 2017, the trust's unplanned re-attendance rate to ED within seven days was generally worse than both the national standard of 5% and the England average.
- Staff appraisal rates did not meet the trust target of 95%, falling considerably short of this in some groups of staff.

However:

- We were assured that patients were receiving timely pain relief. We reviewed 16 sets of patient's notes, which showed pain relief was offered in all applicable cases and was followed up appropriately.

Urgent and emergency services

- There were effective systems in place to address the frequent attenders. Senior staff told us that this was mainly due to patients with complex underlying health problems, like diabetes or mental health issues.
- We observed good MDT working and positive interactions across all staff levels.
- All clinical staff we spoke with demonstrated reasonable understanding and knowledge of the principles of consent and mental capacity, including the care and treatment of patients with a Deprivation of Liberty Safeguards (DoLS) order.

Is the service caring?

Good   

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

- During quieter periods, we observed compassionate care delivered by nurses and doctors. Staff engaged in an open and positive way with patients and their relatives.
- Most patients told us they felt informed about the treatment they would receive and the processes in the department.
- We observed some staff who told patients the general timeframe for being assessed, admitted or discharged. Some patients told us this helped to alleviate anxiety that patients might have over the time they would spend there. However, this did not happen during busy periods.
- The results of the CQC ED survey 2016 showed that the trust scored similarly to other trusts in relation to most questions about understanding and involvement in care and treatment.
- We observed staff providing reassurance and comfort to patients, during quiet period. Staff took time to understand the needs of the patients to enable them to address their concerns. We observed staff taking a detailed history from a patient to ensure they fully understood their circumstances.
- There was a trust bereavement team and there was a protocol on how to deal with relatives who experienced bereavement. A dedicated quiet room and viewing room was available, which was clean. Staff demonstrated compassion when talking about this area.

However:

- General observations confirmed staff considered the privacy and dignity of patients. However, during busy periods, capacity issues and space limitations affected the ability of staff to provide care which maintained the privacy and dignity of patients. Sensitive conversations were easily overheard when patients were nursed on trolleys in the corridor.
- The results of the CQC ED survey 2016 showed that the trust scored slightly worse than other trusts when patients were asked whether they were treated with dignity and respect.
- During busier periods, we observed that staff interactions with patients were abrupt; staff would rush passed the patients and responded to patients in dismissive manner. Some patients told us that they felt that when the department gets busy staff didn't have time to listen to them.
- The results of the CQC ED survey 2016 showed that the trust scored worse than other trusts when patients were asked if they had sufficient opportunity to talk to a doctor or whether members of staff contradicted one another.
- Call bells were not always within easy reach of patients.

Urgent and emergency services

Is the service responsive?

Requires improvement ● ↓

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

- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. Charing Cross hospital did not meet the standard between April 2016 and October 2017 and 84.9% of patients were admitted, transferred or discharged within four hours of arrival in the ED.
- The department was not meeting the needs of people with learning disability (LD) and no specific actions were taken by the department to address the needs of people with LD. Staff showed limited understanding of caring and meeting the needs of LD patients.
- At the time of the unannounced inspection, we observed that capacity remained an issue, with patients being doubled up and waiting on trolleys in majors area. We also observed that patients and relatives were standing in the waiting area and in the corridors of major's area as there were not enough seats for them to sit.
- The department's capacity issue along with its physical layout provided a challenging environment to staff. Five resuscitation bays were frequently used for seven to eight patients.
- There were no posters or information leaflets available for patients detailing how to access PALS or to make a formal complaint. Some patients we spoke with were not aware of how to make a complaint. There was a general lack of health promotion leaflets within the department.

However:

- We found the needs of people living with dementia were being met.
- The department had a 24/7 clinical decision unit (CDU), which was used to accommodate emergency department patients who were awaiting clinical decisions and required an additional period of observation.
- Over the 12 months from September 2016 to August 2017, zero patients waited more than 12 hours from the decision to admit until being admitted at Charing Cross Hospital.

Is the service well-led?

Requires improvement ● ↓

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

- The department was not proactive in their risk assessments. For example, we asked if risk assessments were carried out for the suitability of the dedicated paediatric bay, storage of emergency medicines, safer environment for patient and staff in the ambulatory emergency care unit (AEC) and non-availability of a resuscitation trolley within the major's areas. Senior staff informed that there had never been any incident related to these and the department had done a risk assessment for these. However, none of staff were clear and able to tell us who conducted those risk assessments.

Urgent and emergency services

- Not all risks identified by us during the inspection were reflected on the risk register. For example, low compliance with mandatory training, low appraisal rates, lack of sepsis training for staff, lack of an effective checking system for airway trolleys and emergency medicines on resuscitation trolleys and not meeting the London Quality standard for 16-hour consultant cover at Charing Cross site were on the risk register.
- During periods when the service was very busy we found that the leaders did not have the full understanding of the problems faced as staff were too busy looking after patients to inform leadership. We were not assured that the directorate level leaders had full oversight of the problems faced by staff. For example, senior leaders were not aware of the blocked second exit of the secure room and no immediate actions were taken even when this was highlighted at the inspection.

However:

- Local leadership team was described as visible and proactive by all clinical staff.
- There was good team spirit from the top to bottom of the department. Each member of staff felt their contribution was valued, which meant despite capacity pressures, staff morale was high.
- The trust had agreed to a £3.5 million to invest in the redevelopment of the urgent and emergency department. All staff spoke enthusiastically about this improvement project.

Areas for improvement

Action the trust **MUST** take to improve

- The trust must ensure that control drugs cupboard key is kept securely and access is appropriately restricted.
- The trust must ensure that there are effective checking systems for airway trolleys and emergency medicines stored in the resuscitation bays.
- The trust must ensure that IV fluids are stored appropriately.
- The trust must ensure that all portable equipment is regularly serviced and labelled to indicate the next review date.

Action the trust **SHOULD** take to improve

- The trust should ensure that staff are compliant with hand hygiene practice and 'bare below the elbow' policy.
- The trust should ensure that paper records are stored securely.
- The trust should ensure that all staff are up to date with their mandatory training.
- The trust should continue to work towards improving flow and capacity within the ED to improve time to initial assessment and treatment.
- The trust should ensure that appropriate fall risk assessments are completed in the ED.
- The trust should ensure to meet the RCN standard for a minimum of one registered children's nurse at each shift in UCC.
- The trust should ensure that the ED meets the RCEM Standard for 16 hours consultant cover.
- The trust should ensure that all staff in ED receives an annual appraisal.
- The trust should ensure that IV fluids are stored appropriately.
- The trust should ensure that second exit for secure room is not blocked and staff are aware of how to use that door.

Urgent and emergency services

- The trust should ensure that capacity issues and space limitations do not impact on the privacy and dignity of patients.
- The trust should continue to work towards improving the environment and capacity issues identified within the department.
- The trust should continue to work towards improving their performance in relation to arrival to receiving treatment, four hour performance, total time in ED and patients leaving without being seen.
- The trust should ensure patient information leaflets and PALS leaflet are available in the ED.
- The trust should ensure that they are proactive in their risk assessments and that the risk register reflects all the risks within the department.
- The trust should ensure there are effective systems for staff to escalated problems in a timely manner to the directorate level leaders.

Surgery

Requires improvement   

Key facts and figures

Charing Cross Hospital has 10 main operating theatres and four additional theatres at the Riverside surgical day unit. The service provides emergency general surgery, orthopaedics, urology, gender reassignment surgery, neurosurgery, ear nose throat (ENT) surgery, including head and neck cancer removal, oral surgery, plastic and reconstructive surgery, vascular surgery, podiatric surgery and general surgery. There are 120 beds across four surgical wards in the main hospital and the Riverside surgical day unit.

We spoke with 8 patients and relatives, observed care and treatment and looked at seven care records. We also spoke with 30 staff members at different grades, including allied healthcare professionals, nurses, doctors, consultants, ward managers, matrons and members of the senior management team. We received comments from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of this service

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

- We were not assured that staff had received up-to-date training in all safety systems.
- There were high vacancy rates for nursing staff on the wards.
- We found that not all equipment was appropriately secured or in date for safety testing.
- Although compliance with World Health Organisation safer surgery checklists had improved since the last inspection, audits showed inconsistent performance for all five steps.
- According to the 2016 National Emergency Laparotomy Audit, the hospital performed worse than the national standard and national average for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre.
- Some patients waiting for surgery did not know when procedures would take place and were left uncertain in waiting areas.
- There were long waiting times for elective surgery admissions and the hospital did not meet national targets for any surgery waiting lists and continued to experience significant numbers of 18 week and 52 week breaches in referral to treatment times.
- The average length of stay for patients in urology and ENT was higher than national average.
- Patients had a higher expected risk of readmission for elective admissions when compared to the England average.
- The number of patients whose operation was cancelled and were not treated within 28 days was higher than national average.
- The staff survey showed that less than half of respondents agreed that poor behaviour and performance was addressed effectively and only slightly more than half thought senior leaders were visible and approachable.

However:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Incidents were investigated as appropriate and learning was shared.

Surgery

- Staff recognised and responded appropriately to changes in risks to patients.
- Patients' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice. There was participation in local and national audits. Findings were used to improve care and treatment and patients' outcomes.
- Staff were qualified and had the skills needed to carry out their roles effectively. Learning needs of staff were identified and training was offered. Staff were supported to maintain and develop their professional skills and experience.
- Neurosurgery patients had a much lower expected risk of readmission for elective admissions when compared to the England average. The average length of stay for these patients was lower compared to the England average.
- Patients had a slightly lower expected risk of readmission for non-elective admissions when compared to the England average.
- The NHS Friends and Family Test results showed high levels of satisfaction with some areas achieving 100% recommendation rates from respondents.
- We observed staff demonstrating compassion and kindness when speaking with patients and relatives, maintaining patients' privacy and dignity
- Complaints were dealt with in a timely manner in line with trust regulations.

Is the service safe?

Requires improvement ● → ←

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

- We were not assured that staff had received up-to-date training in all safety systems.
- There were high vacancy rates for nursing staff on the wards.
- We found that not all equipment was appropriately secured or in date for safety testing.
- Although compliance with World Health Organisation safer surgery checklists had improved since the last inspection, audits showed inconsistent performance for all five steps.

However:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Incidents were investigated as appropriate and learning was shared.
- Staff recognised and responded appropriately to changes in risks to patients.

Is the service effective?

Good ● → ←

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

- Patients' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.

Surgery

- There was participation in local and national audits. Findings were used to improve care and treatment and patients' outcomes.
- Staff were qualified and had the skills needed to carry out their roles effectively. Learning needs of staff were identified and training was offered. Staff were supported to maintain and develop their professional skills and experience.
- Neurosurgery patients had a much lower expected risk of readmission for elective admissions when compared to the England average.
- Patients had a slightly lower expected risk of readmission for non-elective admissions when compared to the England average.

However:

- Patients had a higher expected risk of readmission for elective admissions when compared to the England average.
- In the 2016 National Emergency Laparotomy Audit the hospital was given an amber rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was worse than the national standard and national average.

Is the service caring?

Good ● → ←

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

- The NHS Friends and Family Test results showed high levels of satisfaction with some areas achieving 100% recommendation rates from respondents.
- We observed staff demonstrating compassion and kindness when speaking with patients and relatives.
- Patients' privacy and dignity was maintained throughout their journey.
- Patients had access to spiritual support.

However:

- Patients waiting for surgery did not know when procedure would take place and were left uncertain in waiting areas.

Is the service responsive?

Requires improvement ● → ←

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

- There were long waiting times for elective surgery admissions the hospital did not meet national targets for any surgery waiting lists and continued to experience significant numbers of 18 week and 52 week breaches in referral to treatment times.
- The average length of stay for patients in urology and ENT was higher than national average.
- The number of patients whose operation was cancelled and were not treated within 28 days was higher than national average.

Surgery

However:

- The average length of stay for elective neurosurgery patients was lower compared to the England average.

Is the service well-led?

Good  

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

- Local leadership was knowledgeable about quality issues and performance, were aware of the challenges and took actions to address them. They were motivated to achieve improvement. Local leaders in service areas were visible, approachable and supportive to staff.
- There was a good governance framework to support the delivery of the strategy and good quality of care.
- There was a programme of clinical and internal audits, which was used to monitor performance and safety and identify where action should be taken.
- The risk register was well maintained and reviewed regularly.
- There was a positive working culture in the service with good teamwork and staff ready to go the extra mile.

However:

- The staff survey showed that less than half of respondents agreed that poor behaviour and performance was addressed effectively and only slightly more than half thought senior leaders were visible and approachable.

Outstanding practice

The Northwest London RAPID (Rapid Access Prostate Imaging and Diagnosis) pathway for prostate cancer streamlined prostate cancer diagnostics. Multiple visits to obtain a diagnosis were reduced to one in which all diagnostic imaging and biopsies were carried out on the same day. This evidence-based service offered one-stop magnet resonance-imaging and diagnostic biopsy pathway for prostate cancer and resulted in significantly fewer men requiring biopsy.

The Trust's PREPARE for surgery programme was designed to improve patients' condition undergoing surgery. It looked at different factors to focus on before and after a procedure, including physical activity, diet, psychological wellbeing and medication management. The PREPARE for surgery team had been named Patient Partnership and Surgical Team of the Year at the British Medical Journal (BMJ) Awards 2017.

Areas for improvement

Action the trust SHOULD take to improve:

- The trust should ensure that staff has received up-to-date training in all safety systems.
- The trust should continue to address high vacancy rates for nursing staff on the wards.
- The trust should ensure that all equipment is appropriately secured or in date for safety testing.
- The trust should address inconsistent performance for all five steps of the World Health Organisation safer surgery checklist.

Surgery

- The trust should take measures to improve performance for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre as published in the 2016 National Emergency Laparotomy Audit.
- The service should ensure that patients waiting for surgery are better informed about their schedule.
- The trust should continue to address long waiting times for elective surgery admissions. The hospital did not meet national targets for any surgery waiting lists and continued to experience significant numbers of 18 week and 52 week breaches in referral to treatment times.
- The trust should investigate and improve average length of stay for patients in urology and ENT, which was higher than national average.
- The trust should investigate and improve a higher expected risk of readmission for elective admissions when compared to the England average.
- The trust should aim to decrease the number of patients whose operation is cancelled and are not treated within 28 days.
- The trust should investigate and take measures to address staff survey results that showed that less than half of respondents agreed that poor behaviour and performance was addressed effectively and only slightly more than half thought senior leaders were visible and approachable.

St Mary's Hospital

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London
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www.imperial.nhs.uk

Key facts and figures

Imperial College Healthcare NHS Trust was formed on October 1, 2007 by merging St Mary's NHS Trust and Hammersmith Hospitals NHS Trust and integrating with the faculty of medicine at Imperial College London.

The trust has 12 registered locations and employs almost, 11,000 staff. The registered locations are:

- Queen Charlottes and Chelsea Hospital
- Western Eye Hospital
- Hammersmith Hospitals
- Northwick Park Renal Centre
- Ealing Renal Satellite Unit
- St Charles and Hammersmith Renal Centres
- West Middlesex Renal Centre
- Brent Renal Centre
- Charing Cross Hospital
- St Mary's Hospital
- Hayes Renal Centre
- Watford Renal Centre

The trust has an estimated range of population served is between 1,500,000 and 2,000,000 people.

The trust has a total of 1,412 inpatient beds spread across various locations:

- 733 Medical beds
- 302 Surgical beds
- 70 Children's beds
- 140 Maternity beds
- 136 Critical Care beds

Summary of findings

- No dedicated End of Life Care beds

Summary of services at St Mary's Hospital

Requires improvement   

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

- The hospital improved its rating of well-led since the last inspection, but the ratings for each of the other key questions remained the same.
- We inspected Urgent and emergency care during this inspection to check if improvements had been made. Our rating of the service stayed the same. We rated it as requires improvement because safe, effective, caring, responsive and well-led required improvement. The rating for well-led improved but the ratings for each of the other key questions remained the same.
- We inspected Surgery during this inspection to check if improvements had been made. Our rating of the service stayed the same. We rated it as requires improvement because safe and responsive required improvement and effective, caring and well-led were good. The rating for well-led improved but the ratings for each of the other key questions remained the same.
- We inspected the Medical care (including older people's care) service in October 2017 because we had concerns about the quality of the service. Our rating of the service stayed the same. We rated it as requires improvement because safe and responsive required improvement, and caring and well-led were good. The ratings for each of the key questions remained the same.
- We inspected the Maternity service in October 2017 because we had concerns about the quality of the service. Our rating of the service went down. We rated it as requires improvement because safe, responsive and well-led required improvement, and effective and caring were good. The ratings for safe, responsive and well-led went down and the ratings for each of the other key questions remained the same.
- We inspected the Outpatients and diagnostic imaging service in May 2017 to check if improvements had been made. Our rating of the service significantly improved. We rated it as good because safe, caring and well-led were good and responsive required improvement. We did not rate effective. The rating for responsive improved and the rating for well-led significantly improved. The ratings for each of the other key questions remained the same.

Urgent and emergency services

Requires improvement   

Key facts and figures

We inspected the following services within the emergency department (ED) at St Mary's Hospital:

- The resuscitation area with six bays
- The three-bedded rapid nurse assessment unit (RNAU)
- The majors area with 16 cubicles
- The ambulatory care area
- The paediatric ED with four cubicles
- The 12-bedded clinical decisions unit (CDU)
- The four-bedded paediatric CDU

We inspected the whole service, looking at all five key questions.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. Following the inspection, we returned for a further unannounced visit out of hours in the evening.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- Visited the ED, looked at the quality of the environment and observed how staff were caring for patients.
- Spoke with 13 patients who were using the service and six relatives or carers.
- Spoke with fourteen managers and divisional leads across each of the services inspected.
- Spoke with 57 other staff members; including doctors, nurses, healthcare assistants, domestic and catering staff, security staff, play specialists, receptionists, administrative staff and allied health professionals.
- Observed two handovers and a bed capacity meeting.
- Reviewed 57 patient care records.
- Reviewed 18 medication administration records.

Summary of this service

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

- The trust was not meeting national standards for median time from arrival to initial assessment or treatment, total time in the emergency department (ED), patients leaving the ED without being seen or four-hour performance. The initial triage of self-presenting patients was conducted by the urgent care centre (UCC), which was locally commissioned and provided by a primary care organisation registered with the CQC. The trust told us that they did

Urgent and emergency services

not have control over this process or access to data relating to this part of the patient pathway, resulting in inaccurate data. However, the trust was unable to produce any data held locally relating to performance against these targets until a time after the inspection. The trust were therefore not able to demonstrate how they assured themselves of performance against these external targets.

- The service did not always have 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. There was a high vacancy rate within the nursing team. High numbers of mental health patients meant that registered mental health nurses (RMNs) often struggled to provide the required enhanced levels of observation needed. The paediatric ED was failing to meet the London Quality Standards for paediatric consultant cover. The department was not meeting mandatory training levels for staff. Staff did not receive any formal training in caring for patients with mental health conditions. Staff appraisal rates did not meet the trust target of 95%, falling considerably short of this in some groups of staff.
- Although record keeping standards had improved since the last inspection with the introduction of the electronic patient record (EPR), risk assessments were not always completed in the clinical decisions unit (CDU) and not all medication records we looked had a documented allergy status. Electronic systems used across the trust did not always 'talk' to one another.
- The department were performing below the national average in many of the Royal College of Emergency Medicine (RCEM) audits.
- The trust's unplanned re-attendance rate to ED within seven days was generally worse than both the national standard of 5% and the England average. We noted low response rates in the NHS friends and family test (FFT), with the percentage of people who would recommend the ED as a place of treatment falling below the national average.
- Capacity and lack of physical space within the department remained an issue, despite the refurbishment that had taken place. Space limitations affected the ability of staff to provide care, which maintained the privacy and dignity of patients. There was no waiting time information on display during our inspection and no patient information leaflets available in the adult ED department. Signage in the reception area and signs leading to the ED from the ground floor were confusing. Waiting areas were small and overcrowded at busy times. Not all portable equipment we checked had been recently serviced and labelled to indicate the next review date.

However:

- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. This had improved since our last inspection.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- 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 provided care and treatment based on national guidance and evidence of its effectiveness. This had improved significantly since the previous inspection.
- The service performed well in the Trauma Audit & Research Network (TARN) audit.
- 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.

Urgent and emergency services

- The dedicated paediatric ED was designed to meet the needs of children.
- Since our previous inspection, the directorate level leadership, culture and overall governance structure had improved significantly.
- The trust 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.

Is the service safe?

Requires improvement ● → ←

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

- At our last inspection, we identified that the department was not meeting mandatory training levels for staff. At this inspection, we found the same to be the case.
- Between May and October 2017, hand hygiene audit results for clinical staff varied between 47% and 88%. The auditing of hand hygiene had been a focus for the trust since the 2014 inspection but still showed varying levels of compliance. The trust told us this was due to a more stringent form of hand hygiene audit being introduced, which had led to reduced compliance rates.
- Not all portable equipment we checked had been recently serviced and labelled to indicate the next review date.
- The trust's median time from arrival to initial assessment was noticeably worse than the overall England median in between August 2016 and July 2017. The trust assured us this was due to was due to a commissioning issue at St. Mary's Hospital urgent care centre and data quality issues. Time to assessment was worse than average for both patients arriving by ambulance and walk-in patients.
- Between June 2016 and July 2017, the trust reported nine "black breaches". A "black breach" occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.
- Risk assessments were not always completed in the clinical decisions unit (CDU).
- The service did not always have 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. There was a high vacancy rate within the nursing team. High numbers of mental health patients meant that registered mental health nurses (RMNs) often struggled to provide the required enhanced levels of observation needed. The paediatric ED was failing to meet the London Quality Standards for paediatric consultant cover.
- The IT system could be slow and electronic systems used across the trust did not always 'talk' to one another.
- Four of the 18 medication records we looked at did not have a documented allergy status.

However:

- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. This had improved since our last inspection.
- Staff kept appropriate records of patients' care and treatment. Issues with the quality of documentation that were found in our last inspection had been resolved.

Urgent and emergency services

- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- 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 used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.
- The service planned for emergencies and staff understood their roles if one should happen.

Is the service effective?

Requires improvement ●

We did not rate effective in the last inspection. This time, we rated it as requires improvement because:

- Eight of 12 patient records in CDU did not contain a completed nutritional risk assessment.
- We were not fully assured that all patients were receiving timely pain relief.
- The department were performing below the national average in many of the Royal College of Emergency Medicine (RCEM) audits.
- Between August 2016 and July 2017, the trust's unplanned re-attendance rate to ED within seven days was generally worse than both the national standard of 5% and the England average. Senior staff also flagged possible issues relating to data quality in relation to these figures.
- Staff appraisal rates did not meet the trust target of 95%, falling considerably short of this in some groups of staff.
- Staff did not fully understand their roles and responsibilities under the Mental Health Act 1983, and how this interacted with the Mental Capacity Act 2005. There was variable knowledge regarding how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. This had improved significantly since the previous inspection.
- Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other preferences.
- The service performed well in the Trauma Audit & Research Network (TARN) audit.
- 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.

Is the service caring?

Requires improvement ● → ←

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

Urgent and emergency services

- During the course of inspection, we observed care that did not maintain privacy and dignity of patients attending the adult ED. Capacity issues and space limitations impacted on the ability of staff to provide dignified care. Sensitive conversations were easily overheard when patients were nursed on trolleys in the corridor. We witnessed that no screens or barriers were used when examination was taking place on these patients. Cubicles within the majors department were too small to allow direct transfer hoist transfers, or trolley to bed transfers using patient transfer slides, so patients had to be moved out to the corridor space in order to do this.
- We noted low response rates in the NHS friends and family test (FFT) at the time of our last inspection. This remained an issue in the adult ED, with an overall response rate of 6% between April 2017 to the time of inspection. This was markedly lower than both Charing Cross ED (26%) and the hospital's paediatric ED (17%).

However:

- Staff generally cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff usually provided emotional support to patients to minimise their distress. A dedicated full-time play specialist worked in the ED to support children whilst receiving treatment. Volunteers were also present in the paediatric ED waiting area to supervise and play with the children whilst they waited to be seen.

Is the service responsive?

Requires improvement ● → ←

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

- At the time of our last inspection, we found the signage in the department to be confusing. This was still the case in this inspection, especially in the reception area and signs leading to the ED from the ground floor.
- There was no waiting time information on display during our inspection and staff did not routinely inform patients of anticipated delays to treatment.
- Refurbishment work had taken place across the department since the last inspection, but available space and capacity remained an issue. Waiting areas were not ideal. Patients were often nursed in trolleys in the corridor for extended periods.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. Data provided by the trust following inspection showed that patients arriving to the hospital via ambulance (excluding blue light ambulances) were treated within an average of 77.9 minutes (November 2016 to October 2017).
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. Between September 2016 and August 2017, an average of 65.6% of patients were admitted, transferred or discharged within four hours from the adult ED.
- There were no patient information leaflets available in the adult ED department.

However:

- The dedicated paediatric ED was designed to meet the needs of children.
- The service had made some adjustments to take account of patients' individual needs.

Urgent and emergency services

- 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 ● ↑

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

- When asked to provide data that focused on arrival in the ED to time to assessment or treatment, the trust were unable to produce this information without considerable delay. We were therefore not assured that the trust was monitoring performance effectively against agreed standards.
- Although the trust had improved governance arrangements since our last inspection, not all the risks identified on inspection were not reflected on the risk register. There was not always a proactive approach to identifying and documenting potential risk.

However:

- Since our previous inspection, the directorate level leadership had changed and had become more clinically driven focusing more on what mattered to frontline staff. Leaders were described as visible and approachable.
- The trust had a vision for what it wanted to achieve and created workable plans in relation to this. Plans were developed with involvement from staff, patients, and key groups representing the local community.
- There was an open culture within the department where nursing staff told us that they were encouraged to raise any concerns about safety.

Outstanding practice

The major trauma centre within the department achieved good outcomes in the Trauma Audit & Research Network (TARN) audit. The trauma department was part of the 'Redthread' youth violence intervention programme, which ensured seven-day support from a youth worker embedded in the hospital. Any practitioner could refer a child or young person brought into department where there was a suspicion of violence, assault and/or exploitation as their index admission reason. As a major trauma centre for patients with gunshots or stab wounds, the hospital had developed a new patient pathway based on military medical techniques. Staff were undergoing teaching, scenarios and desktop exercises designed to help them deal with major trauma and incidents more effectively.

A dedicated full-time play specialist worked in the ED to support children whilst receiving treatment. Volunteers were well placed in the paediatric ED waiting area helping to supervise and play with the children whilst they waited to be seen.

Areas for improvement

Action the trust **MUST** take to improve

- The trust must ensure that they are monitoring performance effectively against agreed standards.
- The trust must ensure that all portable equipment is regularly serviced and labelled to indicate the next review date.

Action the trust **SHOULD** take to improve

- The trust should ensure that all staff are up to date with their mandatory training.

Urgent and emergency services

- The trust should continue to audit hand hygiene and work to improve this.
- The trust should continue to work towards improving flow and capacity within the ED to improve time to initial assessment and treatment.
- The trust should ensure that appropriate risk assessments are completed in the clinical decisions unit (CDU).
- The trust should continue to proactively manage recruitment and retention of nursing staff.
- The trust should consider whether numbers of registered mental health nurses (RMNs) in ED are sufficient to keep vulnerable patients safe.
- The trust should ensure that the paediatric ED meets the London Quality Standards for paediatric consultant cover.
- The trust should consider how to improve IT systems across the department to enable easier sharing of information.
- The trust should ensure that all patients have their allergy status documented on all medication records.
- The trust should ensure that all patients receive timely pain relief and that this is documented in their records.
- The trust should further investigate why the trust's unplanned re-attendance rate to ED within seven days was generally worse than both the national standard and the England average, and work to improve this.
- The trust should ensure that all staff receive an annual appraisal.
- The trust should provide training to all staff on treating patients with mental health conditions.
- The trust should ensure that all capacity assessments are fully documented.
- The trust should ensure that capacity issues and space limitations do not impact on the privacy and dignity of patients.
- The trust should continue to consider how to improve low response rates in the NHS friends and family test (FFT) in the adult ED.
- The trust should consider how to inform patients of anticipated delays to treatment.
- The trust should improve the signage leading to the ED from the ground floor.
- The trust should continue to work towards improving the environment and capacity issues identified within the department.
- The trust should continue to work towards improving their performance in relation to arrival to receiving treatment, four hour performance, total time in ED and patients leaving without being seen.
- The trust should ensure that they are proactive in their risk assessments and that the risk register reflects all the risks within the department.
- The trust should ensure patient information leaflets are available in the adult ED department.

Surgery

Requires improvement   

Key facts and figures

Surgery services at St Mary's Hospital are provided within the surgery, cardiovascular and cancer division, which includes nine specialties. The hospital has four surgical inpatient wards, a surgical assessment unit and pre-operative assessment unit. The major trauma centre provides care and treatment for patients that can be referred from eight London hospitals that collectively provide care for over two million patients. The hospital is also a major vascular tertiary centre for complex vascular surgery and a surgical innovation centre provides dedicated specialist care including bariatric surgery, urology and ear, nose and throat treatment.

To come to our ratings we spoke with 43 members of staff across clinical areas and management teams. We spoke with 10 patients and relatives and looked at 19 patient records. We also reviewed over 180 additional pieces of evidence.

Summary of this service

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

- There were significant environmental challenges in main theatres that were not well managed. This included widespread damage to fixtures, fittings and equipment and an ineffective maintenance programme.
- Infection control standards in theatres were inconsistent and as a result, risks to patients and staff were high.
- Adherence to the World Health Organisation safer surgery checklists was variable during our observations and a task group had been set up to address on-going concerns.
- Five specialties participated in the Department of Health 'Getting it right first time' project and used narrative feedback to drive improvements in evidence-based care and treatment.
- Overall compliance with the monthly safer procedures audit was consistently high, with some areas for improvement in individual specialties.
- The trust did not meet the tolerance of 1% of patients waiting more than six weeks for diagnostic assessment in any month between April 2017 and September 2017.
- Patients regularly spent more than 24 hours in theatre recovery due to a lack of capacity elsewhere in the hospital.
- The average length of stay for patients in each specialty was higher than the national average and in some cases significantly higher. However, this was partially reflective of the high levels of complexity the hospital saw and increasing demand on services.
- The hospital continued to experience breaches in referral to treatment times against 18 week and 52 week pathways along with cancellations due to a lack of capacity. However, a multidisciplinary senior team of clinicians and non-clinical specialists were leading a waiting list improvement programme to address a large backlog of patients and improve data management.
- Clinical governance systems did not always identify and address areas of risk to patient care and safety, particularly in relation to theatres.

However:

Surgery

- We found consistently good standards of record keeping in relation to patient notes and risk assessments.
- Inpatient wards demonstrated sustained improvement through the ward accreditation programme and a number of teams had been awarded a gold standard as a result.
- Care and treatment was benchmarked against the national standards and guidance of the Association for Perioperative Practice, the Association of Anaesthetists of Great Britain and Ireland and the Guidelines for the Provision of Anaesthetic Services. This included an audit programme across all specialties, network, and local peer reviews.
- All staff had access to learning from audits and incidents through dedicated audit days.
- Inpatient ward teams had improved nutrition and hydration through targeted work that was recognised with gold standard ratings by the ward accreditation team.
- A dedicated team of clinical practice educators supported nurses to develop their clinical competencies and leadership skills. The team had developed specific competency frameworks to ensure nurses who provided high dependency care had specialist training.
- Feedback from patients and relatives was consistently good and surgery services regularly achieved 100% recommendation scores in the NHS Friends and Family Test.
- There was an embedded culture of dignity, respect, kindness and compassion in each clinical area and staff demonstrated persistence in achieving this.
- In response to emergencies and major incidents in London, the senior team leading the major trauma service had implemented a number of service developments.
- There was a continual drive to improve community services for patients, including those with high levels of vulnerability such as homelessness. This included community liaison teams, rehabilitation teams and social care specialists.
- Quality improvement was evident in all clinical areas led by staff with appropriate experience. This was benchmarked or carried out in line with established frameworks including the US Institute for Health Care Improvement's model for improvement.

Is the service safe?

Requires improvement ● → ←

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

- Seven theatres were in a poor state of repair and presented significant infection control risks to patients. Infection control and environmental control strategies in these areas were insufficient to address the risks.
- Planned preventative maintenance had not addressed significant challenges with the environment and equipment and 45% of theatre equipment was overdue for servicing.
- Documentation relating to cleaning and decontamination was variable and it was not always possible to identify if clinical areas had been appropriately cleaned.
- We found consistent levels of compliance with the World Health Organisation safer surgery checklists through audits; although our observations of practice indicated, there was room for improvement.
- Mandatory training rates were below the trust's minimum standard.

Surgery

- None of the wards were fully staffed against their establishment for nursing.

However:

- Staffing levels in all surgery areas met the requirements of the Association for Perioperative Practice.
- Standards of patient records were good overall and a ward accreditation scheme had identified several areas of consistent good practice.
- Risks to patients were well managed by staff that responded to deterioration quickly using established systems. Rapid responses services were embedded for patients with major trauma and significant injury.
- Incidents were investigated appropriately and learning shared across staff teams.

Is the service effective?

Good  → ←

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

- Significant focus was placed on evidence-based care through a comprehensive audit programme, national and international benchmarking and peer review.
- Senior teams were proactive in identifying areas for improvement in practice through the development of pilot programmes and projects.
- A programme of audit days ensured all clinical staff had access to continual learning.
- Clinical nurse educators and other senior staff ensured clinical teams had access to ongoing development, training and clinical competency supervision.
- Multidisciplinary care was clearly embedded in care plans and was coordinated by specialist teams.
- The directorate performed consistently well in safer surgery audits although specific areas for improvement included the debrief process used by the plastics team.

However:

- Although the trust had a focus on the World Health Organisation standards for safer surgery, there was room for improvement in how these were followed in practice.
- The pre-assessment team did not have link nurses in post for dementia, learning disabilities or infection control.
- The hospital achieved 88% compliance with NHS England D15 standards in relation to trauma care and treatment. Several areas of good practice were noted but there was further room for improvement.
- In the 2016, National Emergency Laparotomy Audit the hospital was given an amber rating for the crude proportion of cases with pre-operative documentation of risk of death, which was worse than the national standard and the national average.

Is the service caring?

Good  → ←

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

Surgery

- The results of the NHS Friends and Family Test indicated people scored surgery services consistently well for recommendation rates. Several areas had a track record of achieving 100% recommendation rates from respondents.
- During all of our observations staff, demonstrated skill and patient in adapting their communication to ensure patients and relatives were involved in care planning.
- All of the staff we observed demonstrated compassion and kindness routinely when speaking with patients and relatives.
- Processes were in place to ensure patients and their relatives had emotional support, such as through the use of an emotional mapping template.
- There was evidence in each clinical area that staff were proactive in finding ways to include patients and relatives in care and treatment planning.

However:

- There was limited patient privacy in the pre-assessment unit as private conversations could easily be overheard.

Is the service responsive?

Requires improvement ● → ←

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

- The average length of stay for patients in each specialty was higher than the national average.
- Patients regularly spent extended periods of time in theatre recovery.
- The hospital did not meet national targets for any surgery waiting lists and continued to experience significant numbers of 18 week and 52 week breaches in referral to treatment times.
- We found that there was poor signage in the hospital and patients were not easily able to locate all relevant surgical services.

However:

- Multidisciplinary teams had developed additional services and support frameworks for the most vulnerable patients, including those experiencing homelessness or living with dementia.
- Review processes were in place to ensure patients cared for as outliers on medical wards received attentive and timely care.
- There was significant focus from the senior divisional team on addressing problems with access and flow. A waiting list improvement programme was in place to identify how waiting lists could be reduced and restructure electronic patient systems to ensure timely care and treatment.

Is the service well-led?

Good ● ↑

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

Surgery

- There was a consistent focus at all levels on driving change and improvements in practice. This included a plan for the centralisation of high dependency beds, which would improve the patient journey.
- All surgical teams demonstrated a positive working culture in which they were empowered to contribute to service development and improvement.
- All of the staff we spoke with described positive and supportive local team working and leadership in their ward or service area.
- We saw evidence of consistent and substantial engagement from staff in all specialties and a wide range of responsibilities.
- The trust engaged with patients through the lay partner and patient representative scheme and we saw people were involved in specific projects.

However:

- Although our overall rating of well led improved, there was a need for more cohesive clinical governance leadership. This was in relation to the management of risk in theatres and the significant deficiencies in infection control and the environment.
- Staff demonstrated variable knowledge of the trust's vision and strategy and said communication was largely carried out by e-mail, which they often did not have time to read.
- Although leadership, governance and risk management frameworks were well structured in the division, there was a lack of evidence of proactive management of the deteriorating condition of theatre estates and facilities.

Outstanding practice

The WLIP was based on the trust's recognition that a key need for the future was sustainability of services.

The QI team worked with the Royal Academy of Arts to support staff who had innovative ideas for improvement and development to be able to design and implement these in a dedicated environment.

Staff who worked in link roles spoke positively of their work to continually improve services or training. For example a healthcare assistant in Charles Pannett ward was part of a link team for improving nursing handovers. This team had submitted a new handover briefing sheet to the senior ward team for consideration.

The division planned to implement a lead matron for mental health to ensure patients with rehabilitation needs following trauma were fully supported.

A surgery team had been awarded a British Medical Journal prize in recognition of an innovative 'prepare for surgery' project that aimed to reduce the length of hospital stays. The programme aimed to improve multidisciplinary input from psychology, nutrition and exercise prior to surgery.

The surgery division was research active and was awarded significant research funding each year that staff used to drive forward innovative practice. This included a recent breath test trial for oesophageal cancer diagnosis.

Areas for improvement

Action the trust MUST take to improve

- The trust must address the low levels of completion of mandatory training amongst medical staff.

Surgery

- The trust must address areas of non-compliance with AfPP guidance in relation to the disposal and management of hazardous and clinical waste.
- The trust must address the poor state of repair of theatres one to seven with urgent consideration of rust and damage to fixtures.
- The trust must implement processes to ensure both daily and periodic cleaning meets trust policy standards, including through the use of effective monitoring and checklists.
- The trust must implement appropriate deep cleaning schedules for theatres.

Action the trust should take to improve

- The trust should continue to work towards sustained and consistent improvement in the use of the World Health Organisation safer surgery checklists.
- The trust should consider implementing dedicated competency training for staff in the pre-operative unit.
- The trust should review access and flow pathways to reduce the risk of patients spending extended periods of time in theatre recovery.

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

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

Regulation

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

Regulated activity

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

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity

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

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Our inspection team

Michelle Gibney, CQC Inspection Manager led this inspection, which was overseen by Nicola Wise, CQC Head of Hospital Inspection.

The team included six inspectors, one assistant inspector, one pharmacist specialist inspector and 12 specialist advisers. Specialist advisers are experts in their field who we do not directly employ.

Two NHS Improvement colleagues joined us for the well-led inspection to review financial governance.

London Borough of Hammersmith & Fulham CHILDREN AND EDUCATION POLICY & ACCOUNTABILITY COMMITTEE 13 March 2018		
IMPROVING TRANSITIONS - TASK GROUP FINAL REPORT		
Report of the Chair – Councillor Caroline Needham		
Open Report		
Classification: For review and comment Key Decision: No		
Wards Affected: None		
Accountable Director: Sarah Thomas, Director for Delivery and Value		
Report Author: David Abbott, Scrutiny Manager		Contact Details: Tel: 020 8753 2063 E-mail: david.abbott@lbhf.gov.uk

1. EXECUTIVE SUMMARY

- 1.1 The Health, Adult Social Care & Social Inclusion Policy and Accountability Committee formed this task group to consider how the council can improve the experience for young disabled people transitioning from social care services for children to social care services for adults.
- 1.2 After considering the shortcomings and challenges of the current arrangements and looking at what parents and professionals thought a good transition experience would be, the task group made the recommendations in the following key areas:
 - The creation of a new ‘Preparing for Adulthood’ team that was co-designed with parents and young disabled people – and was accountable to them.
 - Ensuring there was greater transparency and improved communication.
 - Empowering professionals to do their jobs effectively and efficiently.
 - Improving the housing pipeline so young disabled adults had suitable housing available when they needed it.

2. RECOMMENDATIONS

- 2.1 That the Committee endorse the recommendations of the task group's report (on page 18 of Appendix 1) for approval by Cabinet.

**LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT**

None.

LIST OF APPENDICES:

Appendix 1 – Improving Transitions – Task Group Final Report

Improving Transitions Task Group Final Report

Chair's foreword

The need for the work of the Transitions Working Group stretches back several years.

Disabled young people and their parents have for too long found themselves at the mercy of events rather than shaping them when it comes to the transition from childhood to adulthood.

This was all too apparent in conversations we have had with parents facing that 'cliff edge'. At a time where their children were soon to become adults, there had been no planning, work or joined-up thinking to enable them to move into adulthood without losing access to their current services. And seemingly little vision of what was on offer for them.

This can be extremely stressful for young people and their parents. Changing that is the ambition of this report.

Our recommendations are designed to ensure that professionals work with families from an early stage in identifying the needs of disabled young people and planning for their transition to adulthood. The work needs to involve professionals from a range of disciplines in assessing children's needs, discussing and agreeing the way forward with children and their families, and then reviewing plans on a regular, most likely annual basis.

There are three crucial aspects to this approach.

- The first is interdisciplinary working. The discussions we had in producing this report highlighted that transition involves a wide range of different disciplines (education, children's social care, adult social care, health and housing). But for each of them transition perhaps seems only a small part of their work, so its vital importance can get lost. That's why the establishment of a dedicated team with pooled resources is so crucial – to ensure regular joined-up working, day-in and day-out.
- Communication with young people and their parents is also key. Many of our meetings highlighted the frustration of parents who felt remote and pushed away from decisions being made about their children, and of young people who were not involved in the decisions that affected them. Professionals recognised this problem and are, I believe, committed to finding a way to ensure that young people and their parents have a real voice in transition.
- Regular reviews will also be hugely important. Dialogue with young people about transition and their aims and ambitions should happen regularly. As their ambitions for adulthood change over time, the services and support they

want, whether around work or further education or in other areas, will need to respond.

Ultimately, the success of these recommendations will come if, in time, young people and their families tell us that they have a clear idea about their path for adulthood. One where professionals are assisting them in bringing together their paperwork and reports, discussing their ambitions, brokering opportunities in work and education where appropriate, and regularly reviewing their progress.

Such a vision won't take away all of the difficulties of becoming an adult – there will be all the usual emotional challenges; parents may still have much to do; professionals, parents and young people may on occasion disagree; and this will all take time.

But if put into practice, the recommendations in this report should give disabled young people one of the things they need and deserve – greater and more certain support as they transition to adulthood.

Thanks

This report is the culmination of a number of months of work by the Transition Working Group.

I would particularly like to thank Patrick McVeigh, Sarah Markson and Peter Harden for agreeing to become members of the Group. Their input as parents of children who have been or will be going through transition was invaluable.

I should also like to thank the many dedicated professionals from across children's social care, education, adult social care, health and housing who contributed to our meetings. They gave generously of their time and have helped us to shape some clear recommendations. They are listed in Appendix 1.

The expert guests who attended our meetings also helped to shape the way forward. Their contribution was also invaluable and I should like to thank them sincerely for their time.

I would also like to thank my fellow councillor members of the group, Cllr Caroline Needham and Cllr Marcus Ginn, as well as my colleague Cllr Ben Coleman, for their invaluable contributions.

Finally, this report would not have been possible without the dedication of David Abbott from the Council's Scrutiny Team, who brought the meetings together and drafted the final report. I thank him wholeheartedly for his skilful work.

- Councillor Rory Vaughan, Chair of the Task Group and Chair of the Adult Social Care, Health and Social Inclusion Policy and Accountability Committee

Executive Summary

The Health, Adult Social Care & Social Inclusion Policy and Accountability Committee formed this task group to consider how the council can improve the experience for young disabled people transitioning from social care services for children to social care services for adults.

After considering the shortcomings and challenges of the current arrangements and looking at what parents and professionals thought a good transition experience would be, the task group made the recommendations in the following key areas:

- The creation of a new 'Preparing for Adulthood' team that was co-designed with parents and young disabled people – and was accountable to them.
- Ensuring there was greater transparency and improved communication.
- Empowering professionals to do their jobs effectively and efficiently.
- Improving the housing pipeline so young disabled adults had suitable housing available when they needed it.

The full list of recommendations can be found on page 18 of this report.

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1. Introduction

What we mean by 'transition'

“Transition is an essential part of human life and experience. Here the term is used to refer to the process of change for young people, and those around them, as they progress from childhood to adulthood. This movement can be a time of celebration, change and also challenge for all young people. It is a time when young people are considering and making decisions about their continuing education, work and careers, their social life and where and how they will live.”

- Social Care Institute for Excellence (2014)

As young disabled people grow older there comes a point when they have to 'transition' from children's social care services to adult social care services. This transition covers a period before the move, where options are discussed and arrangements are planned, the transfer itself, and then a period of support afterwards. This process has to be carefully planned so young disabled people and their families feel prepared - and to make sure there are no gaps in the vital care and support services that they receive.

2. Objectives of the task group

Why we started the task group

For a variety of reasons, the experiences of young disabled people and their families going through the transitions process is still very variable. For many it is a time of anxiety and uncertainty.

The Health, Adult Social Care & Social Inclusion Policy and Accountability Committee formed this task group of councillors and parents to consider how the council can improve the transition experience and outcomes for young people and their families. During the course of the inquiry the task group met with parental advocacy groups, council officers in children's services, adult social care, health, and housing, education and medical professionals, and representatives from the third sector.

Goals

The task group set itself the following three objectives; to understand the current model and its shortcomings and challenges, to consider what a 'good' transition experience would be, and to make recommendations for improvements.

3. The current offer

Teams and services

Hammersmith & Fulham provides a 'Transition Service' for young people with learning disabilities. This service is made up of the following components:

- Two social workers (one permanently funded by Adult Social Services and one funded by the Clinical Commissioning Group)
- Virtual Team (this has ad-hoc membership supplied by Adult Learning Disability practitioners from Psychology, Psychiatry, Speech and Language Therapy, Nursing, Physiotherapy and Occupational Therapy)
- Key workers for children with Special Educational Needs
- Disabled Children's Team (Children's Social Care)
- Children's Educational Psychology Service

There are additional links with other services, including Looked After Children, the Leaving Care service and the Youth Offending Team, as well as the Child and Adolescent Mental Health Service and the Children's Community Nursing Service.

There are a number of commissioned services for this group of young people including special schools, employment services, further education, short breaks, evening clubs, day opportunities, and young carers' support groups.

Current practice

The current practice is outlined as follows:

Publication of the Local Offer

All local authorities are required to publish a 'Local Offer' outlining the provision that is available for all young people with SEN and disabilities, and are required to offer families the option of a 'personal budget' with which to purchase services. H&F's Local Offer can be viewed online at: www.lbhf.gov.uk/localoffer

Social Care

In H&F the transition team only work with young people with learning disabilities. Children are assessed for eligibility for adult learning disability services as they approach the age of 18, which is generally considered to be too late to enable a well-managed transition to adult services.

Education

The Special Educational Needs Service has recently employed key-workers who have a specific focus on young people aged 16-19 and an Assistant Head of Service who is responsible to development of the Local Offer of education provision for children aged 16-25.

The key-workers are responsible for ensuring that the transition from school into post-16/19 provision is managed for a young person once they exceed statutory

school age and, where appropriate, will liaise with colleagues in Social Care and Health. The key-workers are also trained in providing advice and guidance for preparing for adulthood.

Health

From the age of 0-18 the most significant period of coordinated Health input takes place in the first 4-5 years of a child's life and is managed by the multi-disciplinary Child Development Teams. Young people with enduring needs will continue to receive specialised paediatric support from the service up until their 18th birthday. This can include Occupational Health input, Speech and Language and Physiotherapy, Psychology and Music therapy, in some cases specified in an Education Health and Care Plan. All other young people receive various inputs as and when they are required, and these are usually coordinated by their parents/carers via their local GP surgery.

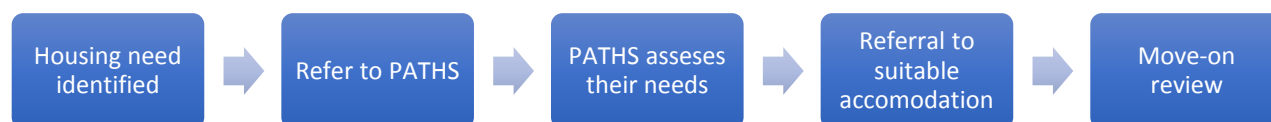
When they turn 18, those young people without complex or enduring needs will continue to access support from their local GP surgery as and when it is needed. Young people with complex needs will also transfer from their specific paediatric support to their local GP. The quality of support that these young people receive from their local GP can vary.

Housing

The Housing Options team manages all aspects of housing advice, assessment, and allocations. Within this section is a specialist team, the Placement and Assessment Team for Homeless Singles (PATHS), who manage referrals to supported housing, including access to the Learning Disability supported accommodation.

PATHS is primarily responsible for trying to prevent homelessness and assess support needs and housing circumstances so that appropriate support can be provided. If appropriate, they will refer individuals moving from residential accommodation, or from their family home, into supported accommodation that will meet their needs.

The process map below shows the route to supported accommodation through PATHS. The PATHS team works closely with ASC to allocate units appropriately.



There are two main providers of supported housing in the borough, Yarrow, and Metropolitan Housing. In addition, there is a quota within the scheme of allocations for 5 general needs homes that are allocated to residents with learning disabilities. There is also up to 40 units available for move on from supported accommodation.

These are separate to the long term residential accommodation, where need is identified and placements matched via social work teams.

Feedback from disabled young people and their families on the current offer

Parents and carers can provide feedback about services through a number of different forums and surveys, including the Children and Families Act Parents Reference Group. In addition the 'customer journey' work undertaken last year by Adult Social Care highlights the frustrations expressed by some parents and outlines challenges for the future.

Most disabled young people and their families are generally satisfied with the local offer, however it is clear that significant frustration is created by overly bureaucratic or unresponsive provision. This feeling is intensified when services fail to coordinate their activities.

The local authority has gathered feedback from parents regarding transition. Below is a summary of the key points from:

- It is essential to have good communication, transparency and clarity from all involved in transition.
- The parents commented that the experience in Hammersmith and Fulham was 'variable'. Those young people already known to Children's services moving to Adult Services had better planning.
- Parents found it hard moving from very child focussed services to adult services which had to cater for the broad spectrum of younger adults to old age.
- A number of parents still felt they had to lead and organise the future plans for their son or daughter but often did not know what was fully available.
- Parents wanted to be empowered but needed to know where to go and what was possible. An effective key worker / coordinator role, having a wide knowledge of transition was needed, guiding parents appropriately on all aspects that affect transition not just placements.
- Parents reported that there was often significant amount of time taken to resolve disputes about future funding of services and this had delayed some young people in receiving the service they needed. 'Parents should not be caught up in this wrangle'.
- Lack of suitable provision of college placements meant that some young people needed to be placed out of borough and that local colleges were only offering four days per week and this was an added pressure to cover for working parents, as well as those at home.
- Parents felt the new EHC process bringing all the agencies together was a positive development.

Young people and parents provided the following feedback on the housing offer:

- They wanted suitable local accommodation that will offer good quality care and support in a safe environment.
- They wanted more options and flexibility to meet their individual needs. For example, some tenancies do not allow hard flooring which might make the accommodation unsuitable - or changes to the environment / eligibility for housing that might enable the family to live together longer (e.g. soundproofing, property size, layout of the property etc.)

- They wanted community supported living, such as a cluster of flats with shared care that enabling living in and being support by the community.
- Families with children have identified the lack of suitable adapted accommodation and challenges with accessing the housing allocations process.
- There is no provision for autism in the borough, such as specialist housing and support services.

Additionally, young people have said that they wanted better opportunities for employment.

Some parents commented on the timing of the involvement of the Transition Team and pointed out that this often occurred too close to the point of transition, creating anxiety about the future.

Young people have also been provided with workshops to enable them to provide views on what they may need or wish for in the design for future commissioned services. A workshop took place last year to which every young disabled person going through transition was invited. The outputs of that workshop are much the same as the issues above - the full report 'Children and Families Act SEN changes' is available on the Hammersmith and Fulham Website.

4. The challenges for transition services

Supporting disabled young people in their transition to adulthood is challenging for service providers the following key reasons:

1. Individual needs

The process is individual to the needs and aspirations of each young person.

2. Changing needs over time

Transition is a fluid process, spread out over a number of years.

3. Multiple transitions

Young people move from one service to another at different ages. For example, a disabled young person may move from paediatric to adult health services at 16, then at 18 move from children's to adult social care. Each of these transitions is likely to occur independently of each other, which means that young people and their families may repeatedly have to deal with new agencies and professionals, re-telling their story each time.

4. Greater demand and more complex needs

Medical advances mean that more young people with a range of different disabilities and complex medical conditions are living into adulthood than ever before.

5. Insufficient planning and reduced support

The point at which young disabled people move from children's to adult services needs to be planned for years in advance, yet planning is often poor. The reduced support which they then get from adult services compared with children's services comes as a shock to many young people and their families, who often compare this to falling off a cliff.

6. Shared responsibility and accountability

Transition is too often seen as something which need to be addressed individually by children's services or adult services, instead of both addressing it equally.

7. Lack of resources

Young disabled people often find the adult services they need inadequate. They want services which enable them to lead ordinary lives, including a social life. They want a feeling of freedom and not being overwhelmed within adult environments and at the same time as being offered appropriate support.

This will only be exacerbated by the extension of some Education Health and Care Plans to the age of 25. The requirement created the following two specific challenges for local authorities:

- The offer of high quality specialist provision for post 16 and post 19 education is currently underdeveloped. Local authorities need to quantify the number of young people who are approaching transition at 16 and at 19 years of age and will qualify for an Education Health and Care Plan and, on the basis of this demand, will need to develop their local offer to support the transition to adulthood, including planning for young people's employment and independence in or near their local community.
- There is no extra funding in the system to deliver this specialist provision; therefore this extension of the age range represents a financial risk to the High Needs Block within the Dedicated Schools Grant if it is not closely managed and delivered economically in partnership with Adult Social Care and Adult Health Services.

To be effective, pathways to employment for Young People with SEND must be personalised. By having an individualised approach, the educational programme will build on existing strengths, and support the young person to learn the skills they need for their next step.

The local offer of FE and third sector provision is intended to provide a continuum of employment opportunities. This continuum can include 'job carving' where a learner may carry out a specific element of a job, voluntary opportunities, paid work, part time work, involvement in a social enterprise or supported employment.

8. Differing eligibility criteria

Young people with autism and those who are considered vulnerable, as well as looked after children, are often seen as falling through gaps when transferring to adult services because the eligibility criteria for access to support is often different to that for children's services.

Furthermore, should a child have a Statement of special educational needs or an Education, Health and Care Plan, the joint assessment and planning process between social care and education at age 14 needs to be coordinated in a more efficient way. There is a need to ensure that eligibility criteria for services are aligned between Children's Social Care and Adult Social Care and that a shared language is used between the services.

9. Sufficiency of the local offer and out of borough placements

The Children and Families Act, enacted in September 2014, extended the age range of eligibility to a formal assessment and support plan for Education, Health and Care needs from 0-16 to 0-25. This means that there is a requirement for local authorities to provide a seamless transition between children's services, adult's services, and health services - and ensure that there is a high quality offer of specific courses and support for young people aged 16-25 with SEN and disabilities.

When there is a lack of specialist local provision that meets the needs of a child of statutory school age, the local authority often has to seek a placement with an independent provider outside of the borough. There are four overarching issues with placing a young person at such a provider:

- The young person will generally need to travel long distances away from home each day (or in the case of residential placements, live away from home), which causes disruption to family life and does not allow for inclusion in the local community.
- The local authority has less influence over the quality of the provider and less powers of intervention to ensure standards are consistently high.
- Health transitions can become more complicated, as providers from other authorities become responsible for the delivery of health support.
- Subsequent transitions to local services are challenging when a young person returns to the borough as he or she will have built up an existing network of support in a location that is a significant distance away from home.

10. Housing

Some of the current supported housing buildings are not fit for purpose. In LD supported housing there are voids because some of the buildings are not accessible for the customer's needs.

There are residents in supported housing with high and complex needs in shared accommodation, where it is difficult to find a suitable match to the void room.

Supported accommodation accessed through the PATHS team is intended as short term, and not designed to give long-term tenancy solutions. Individuals are supported to learn independent living skills to enable them to move-on, although some residents' needs may be best matched to the current environment and may never be able to live independently. There is the provision to support individuals to move on to their own long term tenancies

Insufficient local provision to meet the current customer needs. Largely this is due to the suitability of the buildings, and in some circumstances, the level of care that is available is not sufficient to meet needs.

Low levels of turnover of suitable properties within general needs, and specifically of properties with adaptations or that are suitable for adaptations.

A general lack of affordable housing supply in the borough, due to high land values and restricted delivery generally.

11. Employment - Providing pathways into employment

Employment for adults with a learning disability is nationally monitored and remains at a very low level in Hammersmith & Fulham compared to the rest of London and the UK as a whole. Work needs to be done to improve the opportunities for education leading to meaningful work experience and employment for young people with complex needs.

12. Health

There is often a significant difference between health services for children and those for adults, and the level of support provided to a young person and their family can be seen to reduce once a young person turns 18. Communication between children's health practitioners and, for example, General Practitioners is of paramount importance to ensure a smooth transition between these services.

Furthermore, the recently produced Child and Adolescent Mental Health Service Task & Finish Group Report recommended introducing Transition Champions into Adult Mental Health services to strengthen the pathway for young adults requiring support. This suggestion has been endorsed by Hammersmith & Fulham's Health & Well Being Boards and the Executive Director of Adult Social Care.

13. Projections - Data sharing and projecting the needs of young people approaching transition

Within the Adult Social Care client database, a new area for data collection has recently been set up to capture information on young people aged 14 and above who are in transition. This is being populated manually by transition staff from Adult Social Care based on information provided by Children's Services. This will enable Adult Social Care to plan services for young people and captures information relevant to:

- health condition / disability
- housing need
- if the young person has needs resulting from challenging behaviour

While this new dataset is useful, it doesn't address the new requirements for the Children and Families Act in projecting demand across health and SEN needs and therefore facilitating the development of a medium-to-long-term commissioning strategy.

Active, collaboration between Public Health, CCGs, Adult and Children's Social Care is urgently required to strengthen data capture and analysis to improve planning for transitions and projected need.

5. What good looks like

H&F's vision and options for improving transitions in Hammersmith and Fulham

Our vision is for a Hammersmith and Fulham transition service that is for all children and young people with a physical or learning disability and/or complex medical needs, and their families. We fully endorse the National Institute for Health and Care Excellence's recommendations and principles from their guideline publication, 'Transition from children's to adults' services for young people using health or social care services'.

Our transition services will be based on listening to what young disabled people and their families want and by starting to plan well in advance, we will;

- ensure a smooth transfer for young disabled people from children's to existing adult social care, health and education services and;
- develop new adult services which respond to young disabled people's additional needs.

Once a young disabled person reaches the age of 14, a range of children and adult services will come together to agree a transition plan, encompassing all relevant local agencies. This plan will ideally taper services as needed to make transition less of a 'cliff edge' for families.

Options for improvement

Improving the transition team model in Hammersmith and Fulham

Other models of provision exist and commonly feature shared staff members between Children's and Adult Social Care teams and assessment processes initiated at an earlier stage. A similar model could be implemented in Hammersmith and Fulham, along with changes in practice that would make the coordination of client groups and activity more straightforward, for example undertaking the psychological learning difficulty assessments at the age of 16 rather than at 17 years 9 months as is current practice.

Developing the post-18 local offer for social care services

Support services and respite functions within Adult Social Care provide support for people until old-age - this leads to young people having to spend time in settings which are not age-appropriate. Children's and Adult Social Care should work together to understand how current provision could be used differently to better support this cohort of young people.

There is a risk that this work could essentially move the 'cliff edge' from 18 to 25. However, it is considered that there is much more potential and capability for a 25-year-old to transfer into adult orientated services than an 18 year old.

Improving the quality of the adult health offer

At 18 years old, young people with complex needs will transfer from their specific paediatric support to their local GP. The CCG have recently undertaken an audit of young people aged 16-25 with complex needs in Kensington and Chelsea and have established that there are 24 young people using the adult GP Service. It is estimated that there are roughly 100 young people across Hammersmith and Fulham, Kensington and Chelsea, and Westminster.

The overarching issue for Health is the need to increase the provision of specialist services currently on offer for young people once they become adults (for instance, Speech and Language Therapy). A coordinated approach to the strategic commissioning of such services is of paramount importance.

Officers in Adult Social Care have also highlighted the needs for greater engagement of Adult Mental Health Services in assessment and planning for young people in transition.

Improving the further education offer and pathways into employment

In order to address the need for more local specialist provision that helps promote independence and provides pathways into employment for young people aged 19 and above, the SEN Service have been actively working with Special Schools and Further Education Colleges in Hammersmith and Fulham, Kensington and Chelsea and Westminster. Examples of activities that are currently underway include:

- Providing virtual local authority support teams to train FE providers as well as offering outreach support and guidance in supporting young people with SEND
- Development of post-19 provision at Queensmill Special School specifically for young adults on the autistic spectrum, which will follow the four key pathways in the Preparing for Adulthood Framework: Employment; Independent living; Community inclusion; Health
- Implementation of 'Project Search', which will support young people with special educational needs and disabilities into meaningful supported employment opportunities

The Queensmill offer has been running from September 2015, delivered in partnership with Adult Social Care, using some of their respite facilities, to help ease the transition from Children's Services and a school environment into a more adult orientated setting that promotes independence and employment.

A working group, led by Queensmill Governors, worked in partnership with officers from Children's Services and Adult Social Care to develop a permanent model based on the creation of a charitable incorporated organisation. This was implemented late in 2016. Discussions are also taking place with Jack Tizard to develop a similar model for young people with profound and multiple learning disabilities.

Expanding the supported internships programme

Supported Internships is a study programme specifically aimed at young people aged 16-25 with an EHC plan who want to move to employment but need extra support to do so. The internships are structured study programmes, based primarily at an employer, where most of their time is spent on a work placement (4 days a week, working around 10am until 3.30pm) coupled with a personalised study programme that gives them the opportunity to study for relevant qualifications.

In the first year of delivery the programme took on eight young people and the 2017/18 cohort expanded that to 13. Officers said the increase in interest was due to the Supported Internship Fair held at West London College on 26 January 2017 - where existing interns had a stall and promoted the opportunities across H&F Council and L'Oréal.

Officers reported that all of the interns had developed confidence and employability skills thanks to the support from their job coaches and tutors. Four young people have moved into jobs and Action on Disability are working with the remaining learners to progress them into paid work.

The Council is keen to develop this programme further and are planning to develop more roles in areas such as: a children's centre nursery, ICT, the post room, AMEY, human resources, libraries, parks, and a local leisure centre. L'Oréal are also looking to expand their roles to include their academy, restaurant, post room, and HR. Officers are also in discussions with other businesses to bring them into the programme.

Improving the planning for transition and links between health services for children and adults

An option to improve the quality of support that young people with special educational needs and disabilities receive from their local GP when they turn 18 is to provide specific training for GPs. However, it is not considered that this will offer good value for money as most GPs have either only one or two young people to support, or in some cases they have no young people with enduring or complex needs within their caseload.

The Clinical Commissioning Group is currently undertaking a review of the templates to be used for an annual health check for young people with learning difficulties. Once the templates are finalised, it is envisaged that they will be used by health professionals each year from when the child turns 14, and will ultimately inform transition needs at an early stage, enabling planning processes to be completed in good time. The CCG still need to understand how this will be planned for and implemented in the medium to long term.

The CCG are also developing local coordinating roles for young people with complex needs, based on the existing Primary Care Plus / Care Coordinators Roles. An option is to consider whether there is a need to increase the number of these roles for children and young adults to support effective transition. Furthermore, the 'Connecting Care for Children' initiative is aiming to provide GPs with wider support

when involved in transition work. The programme is at an early stage, but its progress is being monitored.

Improving the supported housing offer for young people aged 18 plus

Service users and advocates want the following:

- To have an option of moving into shared accommodation with their peers.
- To be close to family and friends.
- A supportive housing application process and transparency on banding decisions and reviews.

To make that a reality the council has made housing for disabled people an important element of the draft Housing Strategy 'Delivering the Change We Need in Housing'. Section two of the draft strategy 'Meeting Housing Needs and Aspirations' includes proposed actions for meeting the housing needs of disabled people, including those with Learning Disability'.

The actions are:

- Continue to implement the Learning Disability accommodation and support strategy and work with key stakeholder to deliver this
- Undertake a review and reconfigure learning disabled supported housing provision
- Map the system for updating and maintaining the accessible housing register and make recommendations for improvements
- Review and improve the system for void notification and allocation of adapted properties
- Review affordability of social housing and options for those on disability benefits and who are unlikely to be able to work
- Work with stakeholders to improve access for vulnerable groups and ensure that council staff have appropriate training to enable them to identify and respond to needs
- Explore with Adult Social Care and Health initiatives to provide innovative preventative services
- Improve access to the social housing system e.g. staff training and changes to the registration process

6. Recommendations

We want a transition service that is for all children and young people with a physical or learning disability and/or complex medical needs, and their families. Transition services will be based on listening to what young disabled people and their families want and, by starting to plan well in advance, it will ensure a smooth transfer from children's services to adult social care, health and education services. To make this vision a reality we recommend the following:

1. A new 'Preparing for Adulthood' team

The key to achieving our vision for a better transition service is the creation of a new 'Preparing for Adulthood' team. Rather than having separate groups in Children's Services and Adult Social Care there should be a single team that brings together professionals from both departments. This team would work with young disabled people throughout their transitions journey - from the age of 14 to 25 - ensuring they have the support and guidance they need to achieve the best possible outcomes.

- 1.1 **Funding** - The team will be funded from pooled budgets from both Children's Services and Adult Social Care but will have the autonomy necessary, through delegated powers, for agile decision making.
- 1.2 **Staffing** - The team would be multi-disciplinary - including staff currently working within Children's Services, Adult Social Care, and SEN key working in Health roles.
- 1.3 **New ways of working** - On creation, this new team would lead a review of the protocols, procedures, and ways of working around transition to improve their clarity, efficiency, and responsiveness.
- 1.4 **Advocacy** - There should be a shared understanding of cases to take the burden off parents. The new team should have an advocacy and understanding role to guide parents through the options and pathways open to them.
- 1.5 **Co-design and accountability** - The new service should be co-designed with parents and young disabled people and once it is up and running they should be able to feed into its management and development. This could be achieved through a 'shadow board', similar in concept to a board of non-executive directors.

2. Greater transparency and improved communication

- 2.1 Communication with young disabled people and parents should be improved. They need to understand how decisions are made and why. The young person's pathway and the options available to them should be clear and transparent to everyone involved and it should be reviewed on a regular basis.

The end goal should always be in sight and parents and professionals should have a shared view.

- 2.2 The new Preparing for Adulthood team should create a new set of forms and documentation that are accessible, clear, and transparent to users.
- 2.3 The transitions information on the LBHF website should be updated to reflect the Preparing for Adulthood team's new ways of working and to bring it in line with best practice examples from around the country.
- 2.4 The council should encourage partners to sign-up to a 'duty to communicate' - an agreement that they will be meaningfully involved in discussions at panels and annual reviews. If professionals aren't able to attend meetings they should provide written evidence to ensure important decisions are not delayed.

3. Empowering professionals

- 3.1 To ensure panel meetings and annual reviews are meaningful and efficient, the council should empower professionals by devolving decision-making down wherever possible. Team managers should be trusted to make the right decisions.

4. Improve the housing pipeline

- 4.1 The council's Housing department should work closely with the new Preparation for Adulthood team and be involved in the annual assessment process. There should be a clear pipeline, using data from the Preparation for Adulthood team, to accurately predict the numbers of young disabled people coming through the system and their likely housing needs. This would allow for clearer communication with parents about their housing options.

Task Group Contributors

Members of the task group

Councillor Rory Vaughan, Chair
 Councillor Caroline Needham
 Councillor Marcus Ginn
 Patrick McVeigh, Action on Disability
 Sarah Markson, Parentsactive
 Peter Harden, expert by experience

Guest experts

Amanda Roles, Senior Manager, HF Mencap
 Cathy Welsh, Headteacher of Jack Tizard School
 Freddie Adu, Headteacher of Queensmill School
 Gabrielle Zepf, Action on Disability
 Gina Gerrard, Parentsactive
 Nandini Ganesh, Parentsactive
 Ranjit Kang, Social Care Lead for Adults in H&F at WLMHT
 Suky Macpherson, Senior Clinician, Child & Adolescent Mental Health Services at WLMHT
 Zöe Bloomfield, Clinical Business Unit Manager for 0-19 H&F
 Steve Buckerfield, Head of Joint Health Commissioning, Children's Joint Commissioning

Supported by

Councillor Ben Coleman, Cabinet Member for Health and Adult Social Care
 Councillor Lisa Homan, Cabinet Member for Housing
 Steve Miley, Director for Family Services
 Ian Heggs, Director for Education
 Lisa Redfern, Assistant Director of Integrated Care, Adult Social Care
 Mandy Lawson, Assistant Director, SEND and Vulnerable Children's Service
 Jo Baty, Programme Manager, Children's Services
 Mary Dalton, Head of Complex Needs, Adult Social Care Commissioning
 Viv Whittingham, Head of Care and Assessment Service
 Becky Powell, Commissioning, Transformation and Contracts Lead
 David Burns, Head of Housing Strategy, Housing Growth & Strategy Management
 Lucy Baker, PATHS Manager, Housing Advice and Assessment
 David Abbott, Scrutiny Manager

References

- A Transition Guide for all Services – Department of Health 2007
- Transition from children's to adults' services for young people using health or social care services - NICE guideline (24 February 2016)
- From the pond into the sea - Children's transition to adult health services - Care Quality Commission (2014)

Task Group Work Programme

Meeting 1 – 21 January – Terms of Reference

The initial meeting of the task group was used to agree the terms of reference. The group was given an initial briefing from officers in Children's Services and Adult Social Care. They then planned a series of meetings on Education, Health, Housing, and a final meeting to agree recommendations.

Meeting 2 – 17 March – Schools and Education

The second meeting looked at the effect of the Children and Families Act and the Care Act on transitions, and the role of schools.

Cathy Welsh (Headteacher at Jack Tizard School), Freddie Adu (Headteacher at Queensmill School), and Nandini Ganesh (Parentsactive) were invited to share their experiences of transitions services from the perspective of schools and parents.

Meeting 3 – 28 June - Health and Mental Health

The third meeting looked at Health and Mental Health services.

Ranjit Kang (Social Care Lead at Hammersmith & Fulham/West London Mental Health Trust), Zoe Bloomfield (CLCH Clinical Business Unit Manager), and Steve Buckerfield (Head of Children's Joint Commissioning - Inner London CCGs and Shared Services) attended to provide insight the perspective of local health service practitioners and commissioners.

Meeting 4 – 28 November – Housing

Officers from H&F's Housing Department outlined the current service, the issues identified by families of disabled young people, the barriers facing the service, and planned improvement projects.

Meeting 4 – 28 March 2017 – Preparation for adulthood team proposal

The final meeting was focused on looking at options for a new 'preparation for adulthood' team – bringing together resources from Children's and Adult's services into a single team. The group also agreed their final recommendations.

Health, Social Care and Social Inclusion Policy and Accountability Committee

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13th March 2018		
GP Prescription Services	CCG	Deferred
Transitions Task Group – Findings	Governance and Scrutiny	Confirmed
Digital Inclusion	Policy	Deferred
CQC Inspection Reports - Imperial	Imperial College NHS Trust	Confirmed

Items for future agenda planning:

- Meal Agenda
- Commissioning Strategy: Providers
- Customer Journey: Update
- Equality and Diversity Programmes and Support for Vulnerable Groups
- H&F CCG Performance
- Integration of Healthcare, Social Care and Public Health
- Listening to and Supporting Carers
- Self-directed Support: Progress Update
- Tuberculosis

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