North West London Hospitals NHS Trust

Central Middlesex Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Good
Accident and emergency	Good
Medical care	Good
Surgery	Good
Critical care	Requires improvement
Services for children and young people	Requires improvement
End of life care	Good
Outpatients	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out this comprehensive inspection because North West London Hospitals NHS Trust had been identified as potentially high risk on the Care Quality Commission's (CQC) Intelligent Monitoring system. We undertook an announced inspection between 20 and 23 May 2014.

North West London Hospitals NHS Trust is located in the London Boroughs of Brent and Harrow, and cares for more than half a million people living across the two boroughs, as well as patients from all over the country and internationally. The North West London Hospitals NHS Trust manages three main sites registered with the Care Quality Commission: Northwick Park Hospital and St Mark's Hospital in Harrow, and Central Middlesex Hospital in Park Royal. St Mark's Hospital as an internationally-renowned centre for specialist care for bowel diseases. The trust has a sustainable clinical strategy with Ealing Hospital to improve patient pathways, underpinned by combined ICT and estate strategies, and a vision to establish Northwick Park Hospital as the major acute hospital of choice for outer North West London.

The services provided at Central Middlesex Hospital were rated as good, apart from critical care and services provided for children and young people. This was due to the lack of paediatric nurses and equipment available in the outpatients clinics. The new building provided good facilities and enhanced the way staff felt about providing good care. However, there was a general concern among staff about the future of the hospital.

Our key findings were as follows:

- Staff were caring and provided individualised care to patients.
- The hospital was clean, and patients were complimentary about the food provided.
- Staffing levels were sufficient in most areas for care to be given in a timely manner.
- Outpatient facilities for children were not utilised, and paediatric nurses were not available in the outpatients department.
- A&E services were a mixture of acute A&E services and a minor injuries unit. This could lead to confusion for the local population as to the services provided on site at any particular time.
- Staff felt disconnected with the main trust site.

We saw an area of outstanding practice including:

- The STARRS service had strong ownership by geriatricians and the multi-disciplinary team. The team was aware of the needs of frail elderly patients who attend A&E. It was introduced by the trust and its partners to mitigate one of the pressures on the A&E service and the hospital's beds.

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

The trust should:

- Review the lack of a paediatric nurse in the children's outpatient department.
- Ensure that critical care services are audited in line with others, so that benchmarking can take place to drive improvement.
- Review the end of life care provision at this hospital, so that patients receive intervention at an appropriate stage.
- Ensure that departments where children are treated are child-friendly.
- Review epilepsy services for children to ensure that current guidance is in place.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Accident and emergency	Good 	The A&E department provided care and treatment that was safe. Completed incident reports had a clear 'lessons learned' approach. Equipment was clean and maintained to the manufacturer's recommendations, with service labels highlighting when the next service was due. Medication was recorded and stored appropriately, with daily checks carried out by qualified staff. Staff had received mandatory training, including safeguarding vulnerable adults and children. Mental capacity assessments were undertaken appropriately and staff demonstrated knowledge around the trust's policy and procedures. Staff took the time to listen to patients and explain to them what was wrong, and any treatment that was required. Patients told us that they had all their questions answered, and felt involved in making decisions about their care. Staff expressed pride to be working in the A&E department.
Medical care	Good 	Central Middlesex Hospital provided safe care to its patients. There were enough medical and nursing staff to ensure that patients received appropriate care and treatment. Staff in medical services were caring and compassionate, and responded to patients' needs effectively. Patients, and those close to them, were complimentary about the way that staff cared for them, and they felt respected by staff. There were enough medical and nursing staff to ensure that patients received appropriate care and treatment, and staff told us that they worked in supportive teams. Patients were able to access medical services in a way that was convenient for them. Staff had received appropriate training to meet the needs of the community, including training in equality and diversity, and dementia. The medical service had clear line management arrangements.

Summary of findings

Surgery	**Good**		Surgical services provided safe and effective care in the areas we visited. There were appropriate numbers of nursing and medical staff, and staff followed guidance when providing care and treatment. Staff were caring and supportive of patients, and made efforts to keep them involved in decisions about their care and treatment. Arrangements were in place to accommodate the different religious and cultural needs of patients. There was usually a suitable flow of patients through the department. However, there were isolated issues relating to inadequate pre-assessments prior to patients being admitted to the department. There were suitable arrangements in place to monitor the quality and safety of the service.
Critical care	**Requires improvement**		The critical care services at Central Middlesex Hospital require improvement. There were appropriate numbers of suitably-trained staff, who worked according to procedures to keep people safe. Staff collected ongoing data on the safety and performance of the department, which indicated positive patient outcomes. Staff were caring towards patients, and were able to respond to fluctuations in demand. However, governance arrangements could be improved, as could the strategy and vision for the department as a whole. While morale within the team was positive, it was not clear how the unit linked with the trust-wide department as a whole.
Services for children and young people	**Requires improvement**		The day surgery unit and the Rainbow Children's Centre at this site was very differently managed from Northwick Park Hospital. The day surgery unit offered good information for families and children before procedures, had good processes and protocols, and families were pleased with the service. By contrast, the outpatient clinics run by the Rainbow Children's Centre gave us cause for concern, because there was no registered children's nurse, and there were some poor practices around medicines management. The clinics were not child-friendly and lacked play facilities.
End of life care	**Good**		We found that the end of life care to patients was good overall. The hospital had good links with the

Summary of findings

			specialist palliative care team (SPCT) and community services to support patients and their families. The SPCT and other services involved in end of life care were passionate, caring and maintained patients' dignity throughout their care. There was clear multidisciplinary involvement in patient care. Patients were involved in advance care planning and their preferences were observed and followed through, when possible and appropriate. People's cultural and religious needs were taken into account. End of life care training was not mandatory within the trust, and this meant that healthcare professionals at the hospital found it difficult to attend the courses provided by the SPCT.
Outpatients	**Good**		Patients received compassionate care and staff treated them with dignity and respect. The environment was clean, comfortable, well maintained and safe. Staff were professional and polite, and promoted a caring ethos. Clinicians took sufficient time in consultations, and patients said that they felt involved in their care. Clinics started on time and generally ran to schedule. The rheumatology clinics were regularly oversubscribed and had long waiting times, but action was being taken to recruit an additional consultant.

Good

Central Middlesex Hospital

Detailed findings

Services we looked at
Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Services for children and young people; End of life care; and Outpatients

Contents

Detailed findings

Background to Central Middlesex Hospital

Central Middlesex Hospital is part of North West London Hospitals NHS Trust and has 180 beds. This CQC inspection was not part of an application for foundation trust status. The trust is currently undergoing a merger with Ealing Hospital NHS Trust, which is scheduled to become effective in October 2014.

Central Middlesex Hospital is in the London Borough of Brent, which is a densely populated multi-cultural, outer London borough located in the north west of London. The population of Brent is 311,215 as recorded in the 2011 Census. The GP registration data shows that the percentage of the population registered with a GP in Brent is 82.4%. Of 326 local authorities, Brent is the 35th most deprived. In Brent, 63.7% belong to non-White minorities. Of these, the Asian ethnic group constitutes the largest ethnic group with 34.1% of the population.

Over the last 10 years in Brent, all-cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen. Life expectancy for both men and women is higher than the England average. Life expectancy is also 8.8 years lower for men in the most deprived areas of Brent than in the least deprived areas.

The trust was selected for inspection as an example of a 'high risk' trust.

Our inspection team

Our inspection team was led by:

Chair: Alastair Henderson, Chief Executive, Academy of Medical Royal Colleges

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission (CQC)

The team included CQC inspectors and analysts, doctors, nurses, patient 'experts by experience' and senior NHS managers.

How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection:

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

Before visiting, we reviewed a range of information we hold about the hospital, and asked other organisations to share what they knew about the hospital. We carried out an announced visit on 21 and 22 May 2014. During the visit we held focus groups with a range of staff in the hospital, including doctors, nurses, allied healthcare professionals and healthcare assistants. We also interviewed senior members of staff at the hospital.

We talked with patients and staff from various areas of the hospital, including the wards, outpatients department and the A&E department. We observed how patients were being cared for, and talked with carers and/or family members and reviewed treatment records of patients. We held a listening event where patients and members of the public shared their views and experiences of the hospital.

Detailed findings

Facts and data about Central Middlesex Hospital

Key facts and figures about the trust

- Beds - 180 Beds
- Inpatient admissions -107,202 2012/13
- Outpatient attendances - 343,967 2013/14
- A+E attendances - 223,343 2012/13
- Births - 5,609 Oct 12 to Nov 13
- Deaths (and by location)
- Annual turnover
- Surplus (deficit) - £20.5m deficit

Intelligent Monitoring

Safe - Risk: 2; Elevated: 0; Score 2

Effective - Risk: 2; Elevated: 0; Score 2

Caring - Risk: 2; Elevated: 3; Score 8

Responsive - Risk: 0; Elevated: 2; Score 4

Well led - Risk: 2; Elevated: 0; Score 2

Total - Risk: 8; Elevated: 5; Score 18

Individual Elevated Risks

- Maternity Survey 2013 C2 "During your labour, were you able to move around and choose the position that made you most comfortable?" (Score out of 10)
- Maternity Survey 2013 C12 "Did the staff treating and examining you introduce themselves?" (Score out of 10)
- Maternity Survey 2013 C13 "Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?" (Score out of 10)
- Composite indicator: A&E waiting times more than 4 hours
- Composite indicator: Referral to treatment

Individual Risks

- 'Never event' incidence
- Potential under-reporting of patient safety incidents
- PROMs EQ-5D score: Knee Replacement (PRIMARY)
- Proportion of patients who received all the secondary prevention medications for which they were eligible
- Maternity Survey 2013 C14 "If you raised a concern during labour and birth, did you feel that it was taken seriously?" (Score out of 10)
- Maternity Survey 2013 C18 "Thinking about your care during labour and birth, were you treated with respect and dignity?" (Score out of 10)
- Healthcare Worker Flu vaccination uptake

Safe:

Never events in past year - 4

Serious incidents (STEIs) - 126 Between Dec 2012 and Jan 2014

National Reporting and Learning System (NRLS)

- Deaths 9
- Serious 17
- Moderate 190
- Abuse 30
- **Total 246**

Effective:

HSMR - No evidence of risk

SHMI - No evidence of risk

Caring:

CQC inpatient survey - **average**

Cancer patient experience survey - **below**

Responsive:

Bed occupancy - 92.9%

Average length of stay - _____

A&E: 4 hour standard - Elevated Risk

Cancelled operations - No evidence of risk

Delayed discharges - No evidence of risk

18 week RTT - Elevated Risk

Cancer wards - No evidence of risk

Well-led:

Staff survey - **average**

Sickness rate 2.9 % - **above**

GMC training survey - **below**

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Good	Not rated	Good	Good	Good	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Requires improvement	Good

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and Emergency, and Outpatients.
2. We have not reported on maternity and family planning at Central Middlesex Hospital. There is a satellite antenatal clinic at the hospital. A brief visit to the clinic did not identify any concerns. The clinic was assessed as good in all areas, but there was insufficient detail to merit a report. High risk mothers are referred to Northwick Park Hospital.

Accident and emergency

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

Information about the service

The accident and emergency department (A&E) at Central Middlesex Hospital provides a service to the local population between the hours of 8am and 7pm seven days a week. Outside of these hours the unit functions as a medical assessment unit (MAU). The department sees around 14,429 patients a year. A purpose-built A&E department is due to open later in 2014 on the Northwick Park Hospital site.

The A&E department has facilities for assessment, treatment of major injuries and a resuscitation area. There is an acute clinical decision unit (ACDU) within the A&E department, for which patients are admitted for up to 24 hours. Patients with minor injuries requiring urgent care are assessed by the Urgent Care Centre, which is run by an independent provider.

Our inspection included one day in the A&E department as part of an announced inspection. During our inspection, we spoke with clinical and nursing leads for the department. We spoke with two members of the medical team, and seven members of the nursing team. We also spoke with three patients and undertook general observations within all areas of the department. We reviewed the medication administration and patient records for patients in the A&E department.

Summary of findings

The A&E department provided care and treatment that was safe. Completed incident reports had a clear 'lessons learned' approach. Equipment was clean and maintained to the manufacturer's recommendations, with service labels highlighting when the next service was due. Medication was recorded and stored appropriately, with daily checks carried out by qualified staff.

Staff had received mandatory training, including safeguarding vulnerable adults and children. Mental capacity assessments were undertaken appropriately, and staff demonstrated knowledge around the trust's policy and procedures.

Staff took the time to listen to patients, and explain to them what was wrong and any treatment that was required. Patients told us that they had all their questions answered and felt involved in making decisions about their care. Staff expressed pride to be working in the A&E department.

Accident and emergency

Are accident and emergency services safe?

Good

The A&E department had systems in place to protect patients and maintain their safety. The department, including the resuscitation area and acute clinical decision unit, was clean, bright and contained adequate disposal bins for clinical and domestic waste. There were adequate staffing levels to provide safe care to patients within the treatment areas and within the acute clinical decision unit. Staff we spoke with had knowledge of the department's practices and the demands placed upon it. The transition of patients from the minor injury/Urgent Care Centre to the A&E department was smooth, with no interruption to patient-centred care.

Incidents

- The trust reported 41 serious incidents (SI) to both the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (STEIS) relating to the A&E departments between December 2012 and January 2014. This included one SI from Central Middlesex A&E department involving an ambulance delay in taking handover of care from the ambulance service.
- Staff told us that they reported incidents via the hospital's internal electronic reporting system, and received feedback on the closure of incidents they had reported.
- We spoke with senior nursing staff who could demonstrate evidence of learning from incidents. For example, ambulances waiting to handover in the A&E department at Central Middlesex Hospital had to wait within the corridor in the major's area and, at times, could not be seen. The department has now moved the ambulance triage area in front of the nurse's station and reception in the major's area, which was a safer environment and was visual reminder to staff that ambulances were waiting.

Cleanliness, infection control and hygiene

- During our inspection we observed all grades of staff using personal protective equipment (gloves, aprons, etc.) as appropriate, and washing their hands between dealing with patients.
- The trust's infection rates for C. difficile and MRSA lie within a statistically-acceptable range for the size of the trust.
- There were hand cleaning stations within all treatment areas, including the acute clinical decision unit. Hand sanitizers were found at each door entrance, and at each individual treatment cubicle.
- Staff demonstrated good underpinning knowledge of the five stages of hand cleaning and aseptic technique with regards to wound management.
- The A&E department, including the resuscitation area and acute clinical decision unit, was clean, bright and contained adequate disposal bins for clinical and domestic waste.

Environment and equipment

- The A&E department will be re-locating to a new purpose-built and designed building later in 2014, at Northwick Park Hospital.
- The resuscitation area was clean and bright. Resuscitation equipment was available and clearly identified, and followed a system that adopted an airway, breathing and circulation management approach within each resuscitation bay. Although the A&E department at Central Middlesex Hospital did not offer a children's A&E service, we saw a bed space within the resuscitation area, which had a specific cubicle with a children's resuscitation equipment trolley to deal with unforeseen emergencies.
- Treatment cubicles and bed spaces within the acute clinical decision unit were clean and well equipped with appropriate lighting.
- Equipment across all areas within the A&E department showed that there was consistency with regards to scheduled servicing. We noted that servicing of equipment was identified through the trust's internal service stickers on each piece of equipment.

Medicines

- During our inspection we checked the records and stock of medication, including controlled drugs, and found correct and concise records, with appropriate daily checks carried out by qualified staff permitted to perform this task.
- Patient prescription charts were completed and signed by the prescriber and by the nurse administering the medication.

Accident and emergency

Records

- We looked at over five sets of patients' records during our inspection. All had completed patient observations with regular re-assessments recorded.
- We observed that patients' records in A&E were kept safe and secure. Records were easily defined between clinical observations and nursing/medical notes.
- Records showed that risk assessments were undertaken in the department when patients were there for some time (it is recommended by the Royal College of Nursing that if patients are in an area for longer than six hours a risk assessment for falls and pressure ulcers should be completed).

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were knowledgeable about how to support patients who lacked capacity. They were aware of the need to assess whether a patient had a temporary or permanent loss of capacity, and how to support patients in each situation. If there were concerns regarding a patient's capacity, the staff ensured that the patient was safe and then undertook a mental capacity assessment.
- According to the A&E mandatory training database, all nursing and medical staff had undertaken training in the Mental Capacity Act (2005).
- We observed nursing and medical staff obtaining consent from patients prior to any care or procedure being carried out.
- Staff gained assistance and advice from mental health services as appropriate in a timely manner.

Safeguarding

- Training records showed that all nursing and medical staff had undergone mandatory safeguarding training at an appropriate level.
- All safeguarding concerns were raised through a robust internal reporting system. The concerns were reviewed at a senior level to ensure that a referral had been made to the local authority's safeguarding team.
- The staff we spoke with were aware of how to recognise the signs of abuse, and the reporting procedures in place within their respective areas.

Mandatory training

- We were provided with comprehensive records of mandatory and supplementary training for all nursing and medical staff, with 100% compliance across the multi-disciplinary teams.
- Mandatory training was provided in different formats, including face-to-face classroom training and e-learning (e-learning is electronic learning via a computer system).
- During our inspection we noted a poster displayed within the nurse's station, stating that there was an opportunity for all staff to place their name down to attend professional development training in their clinical area. Both medical and nursing staff delivered and attended these training sessions.

Management of deteriorating patients

- The A&E department operated a 'track and trigger' alert system, whereby nurses entered the patient's clinical observations into their records. The system then provided a score which was used to alert clinicians of any deterioration in a patient's condition.
- The department operated a triage system of patients presenting to the department, either by themselves or via ambulance, and were seen in order of priority dependent on their condition.
- Patients arriving as a priority call (blue light) were transferred immediately through to the resuscitation area. Such calls were phoned through in advance (pre-alert) so that an appropriate team were alerted and prepared for their arrival.

Nursing staffing

- Information provided by the trust indicated that the A&E department was operating with the correct number of nursing staff within the correct skill sets. Senior staff told us that they were looking at the Royal College of Nursing's policy to determine whether their current staffing reflected it.
- The department had sufficient whole time equivalent (WTE) of nurses with specific paediatric qualifications should the need arise. In order to ensure that they utilised these skills, staff rotated between all areas within the A&E departments, at both Northwick Park Hospital and Central Middlesex Hospital.
- We observed that there was a professional handover of care between each shift.
- All bank and agency staff received a local induction prior to starting their shift.

Accident and emergency

Medical staffing

- The A&E department shared its consultants with Northwick Park Hospital on a rotation basis. Senior doctors were present in the department from 8am until midnight. There were middle grade and junior doctors on duty overnight, with consultants on-call.
- There was a high use of locum middle grade doctors, of which the senior management team were aware. This was particularly true at weekends and out of hours.
- The doctor's rota showed that the locum middle grade doctor use was consistent in using the same doctors who had received the trust induction programme, and were familiar with the department and protocols.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

The A&E services had appropriate policies and protocols in place to ensure effective services. However, we found little evidence that the results of audits were used to improve care within the department. Patients' needs were met by trained and competent staff. Readmission rates were above the national average and out-of-hours services were difficult to access. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for A&E.

Evidence-based care and treatment

- Departmental policies were easily accessible, which staff were aware of and reported that they used. There was a range of A&E protocols available which were specific to the department. Further trust guidelines and policies were available to staff within the A&E department. For example, there were policies on sepsis, needle stick injuries and the stroke pathway.
- There were treatment plans which were based on the National Institute for Health and Care Excellence (NICE) guidelines.
- We found reference to the College of Emergency Medicine (CEM) standards, and spoke with medical staff who demonstrated knowledge of these standards.

Care plans and pathway

- There was a clear protocol for staff to follow with regards to the management of stroke, fractured neck of femur and sepsis. The department had introduced the 'Sepsis Six' interventions to treat patients. 'Sepsis Six' was the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis.
- Nurses at the A&E at Central Middlesex Hospital were able to obtain blood cultures from patients who were suspected to be septic, and therefore were not reliant on doctors to perform this task. A senior nurse told us that this benefited patients, because they were able to be prescribed antibiotics sooner than would otherwise be the case.

Nutrition and hydration

- Nurses in the department carried out intentional care and comfort rounds every two hours with patients, and these included nutrition and hydration.
- Patients admitted within the department were offered food at regular intervals.

Patient outcomes

- Although we were informed that the department took part in national College of Emergency Medicine (CEM) audits, they were unable to provide us with the results of these, or evidence that they had used the results to assess the effectiveness of the department.
- The CEM recommends that the unplanned re-admittance rate within seven days for A&E should be between 1-5%. The national average for England is around 7%. The trust had not consistently performed well against unplanned re-admittance since January 2013. Their rate in December 2013 was 11%. This information was not broken down for each individual A&E department.

Competent staff

- 100% of appraisals of both medical and nursing grades had been undertaken, and staff spoke positively about the process and that it was of benefit.
- We saw records that demonstrated 100% of both medical and nursing staff were revalidated in basic, intermediate and advanced life support.
- We spoke with staff and students who told us that the acute clinical decision unit is an effective area for teaching and learning.

Accident and emergency

Multidisciplinary working

- We witnessed comprehensive multidisciplinary team (MDT) working within the A&E department. Medical and nursing handovers were undertaken separately. Nursing handovers occurred twice a day, and staffing for the shifts were discussed, as well as any high risk patients or potential issues. Medical handover occurred twice a day and was led by a consultant.
- There was a clear professional conjoined working relationship between the A&E department and other allied healthcare professionals within other departments. For example, the trust had a service known as the Short Term Acute Rehabilitation and Re-enablement Service (STARRS). The STARRS service consisted of therapists and nurses who visited the A&E department daily to provide intervention from community services that would enable patients to be discharged home with an appropriate care package and support. The STARRS service was praised by staff, and we saw the service being used during our inspection with a positive effect and patient's outcome.
- Staff we spoke with were aware of the protocols to follow and key contacts with external teams.

Seven-day services

- There was a consultant out-of-hours service provided via an on-call system.
- The A&E department offered all services where required between the hours of 8am and 7pm, seven days a week.
- We were told by senior staff within the A&E department that external support services were limited out of hours, and it often proved difficult at weekends to access these. This had a negative effect on patient discharges and care packages.

Are accident and emergency services caring?

Good

Evidence provided from both prior to our inspection, and from speaking to patients during our inspection, provided us with sufficient assurance that the A&E department at Central Middlesex Hospital was providing a consistently caring service.

The department had worked hard to increase the Friends and Family Test (FFT) response rate. During our inspection we found the FFT questionnaires in a prominent area in view, within the ambulance triage and reception areas.

We witnessed many episodes of caring interactions between patients and staff during our visit. Patients and relatives gave universally positive feedback about their experiences of care.

Compassionate care

- We witnessed multiple episodes of patient and staff interaction, during which staff demonstrated caring and compassionate attitudes towards patients.
- The trust was performing above the England average in the NHS Friends and Family Test in the A&E department, with a score of 65.
- Staff were knowledgeable about the care pathways available to patients.
- We observed that nurses spent time at the patient's bedside explaining what was going to happen during their stay, and answering questions from relatives in a caring and compassionate manner.
- Patients told us that staff dealt with their needs quickly, and were polite when speaking to them.

Patient understanding and involvement

- Patients told us that they felt informed about their treatment plan, and that staff were responsive to their needs. We observed staff explaining to patients if there was going to be a delay in seeing a doctor, what the reason for that delay was, and how long they would have to wait to be seen.
- Patients and relatives said that they would recommend the service to family and friends.
- A patient's relative who told us, "the care was marvellous and everything has been explained in detail".

Emotional support

- We witnessed staff providing patients and relatives with emotional support.
- There were specific information and support services available for relatives following the death of a child.

Are accident and emergency services responsive to people's needs?

(for example, to feedback?)

Accident and emergency

Good

The A&E department was managed well when coping with increased activity, which occurred on a regular basis. The escalation protocol was appropriate, and provided a measurably safe response, as evidenced by patients not waiting above fifteen minutes within the ambulance triage area whilst ambulances were waiting to handover.

Major incident plans were available and practiced in line with trust recommendations.

Service planning and delivery to meet the needs of local people

- The A&E department had an escalation policy which was developed by the management team.

Access and flow

- During periods of high demand, the department was managed proactively by the A&E senior nursing team. There was clear co-ordination within the teams, which achieved a better patient experience and flow through the department.
- The trust was rated within expectations with regards to patient's transition from the ambulance to the A&E department. However, there was a significant contributing factor with regards to proactive bed management that inhibits patient flow and causes consistent ambulance handover delays.
- The trust has struggled to maintain the 95% A&E waiting time target, and many times had been below the England average. The lowest was 84% in April 2013.
- The trust was performing worse than the England average for the percentage of emergency admissions via the A&E department waiting 4-12 hours from the decision to admit until being admitted. In February 2014 the trust was performing at 15% with the England average being 6%.
- The national average for the percentage of patients that left the department before being seen (recognised by the Department of Health as potentially being an indicator that patients were dissatisfied with the length of time they were having to wait) was between 2-3% (December 2012 – November 2013); the A&E departments were at 2% in November 2013 with the highest percentage being 2.5% in April 2013. There was no breakdown of this information for each individual A&E department within the trust.
- Senior staff within the department knew who should be contacted when there were delays to patient flow.

Meeting people's individual needs

- A translation telephone service was available so that patients who were unable to speak English were able to communicate with staff. Within the department, it was possible to request a translator, and staff were aware of this service.
- There were multiple information leaflets available for many different minor injuries. These were available in all of the main languages spoken in the local community.
- The department had designated 'champions' who led on specific areas to facilitate people's individual needs. For example, there were 'champions' for learning disabilities, mental capacity and dementia.
- The department provided a relatives room. This room was adequate for its purpose, and provided relevant information, was comfortable and its décor was appropriate.

Learning from complaints and concerns

- The A&E department promoted the Patient Advice and Liaison Service (PALS), which was available in the hospital. Information was available for patients on how to make a complaint and how to access the service.
- All concerns raised were investigated, and there was a centralised recording tool in place to identify any trends emerging.
- We were told that learning from complaints was disseminated to the team during team meetings, in order to improve patient experience within the department.

Are accident and emergency services well-led?

Good

Local leadership within the A&E department was good, although there was a lack of understanding of the vision for these services in the future. Universally, throughout the

department, there was an acceptance of change, but staff were apprehensive about the forthcoming new A&E department. However, the staff we spoke with did demonstrate an attitude of commitment.

There was a clear demonstrable respect within the teams for the senior nurses and the decisions that they made in the day-to-day running of the department. We saw a good ethos of team working, and staff morale was good.

Vision and strategy for this service

- The future vision for the department was not well described by all staff members. Staff told us that there was a lack of information provided with regards to the new A&E department at Northwick Park Hospital.
- Not all staff that we spoke with were knowledgeable about the trust's vision and journey. This was despite information being available to all staff, in different formats, about the trust's vision and strategy. However, staff were aware of the priorities for the department.
- Staff were provided with updates on any changes to the department's priorities, and its performance against those priorities.
- The transition pathway for patients using the GP-led minor injuries/Urgent Care Centre and the majors A&E service was seamless, and provided a good experience for patients.

Governance, risk management and quality measurement

- Monthly departmental meetings were held. We were provided with minutes of the meetings held over the past six months. There was a set agenda for each of these meetings, with certain standing items, including case reviews, audit analysis and incident reports feedback. Top risks were discussed, including what was being done to mitigate the risks.
- A quality dashboard with up-to-date information was displayed within the A&E department. The board was displayed in an area available for the public and staff to see.

Leadership of service

- There was a strong departmental team, which was respected and led by the senior nurses.
- The management team demonstrated knowledge of the multidisciplinary teams across all grades of staff, and had a passion to drive their team from within. Members of the management team knew the key performance indicators and objectives for the A&E department.

Innovation, learning and improvement

- The department created an environment in which to learn. We spoke with junior doctors and student nurses who told us that their experiences within the A&E department were good, and that they were provided with quality mentoring and teaching time.

Medical care (including older people's care)

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

Information about the service

Central Middlesex Hospital is part of the North West London Hospitals NHS Trust. The location's medical care services include an acute admissions unit (AAU) (Roundwood), a coronary care unit (CCU), medical wards for older people (Gladstone 1, 2 and 3), and a rehabilitation ward (Gladstone 4), which is for older people recovering from orthopaedic surgery.

We spoke with 16 patients, three relatives and 28 staff, including consultants, doctors, nurses, other healthcare specialists and support staff. We observed care, and looked at the care records of 16 acute and medical patients. We reviewed other documentation, including performance information provided by the trust. We received comments from patients and those close to them, and from people who contacted us to tell us about their experiences.

Summary of findings

Central Middlesex Hospital provided safe care to its patients. There were enough medical and nursing staff to ensure that patients received appropriate care and treatment. Staff in medical services were caring and compassionate, and responded to patients' needs effectively. Patients and those close to them were complimentary about the way that staff cared for them, and they felt respected by staff. Staff told us that they worked in supportive teams.

Patients were able to access medical services in a way that was convenient for them. However, there were delays to patients' treatment when a surgical consultation was required. Staff had received appropriate training to meet the needs of the community, including equality and diversity, and dementia training. The medical service had clear line management arrangements.

Medical care (including older people's care)

Are medical care services safe?

Good

Central Middlesex Hospital provided safe care to its patients. Patients consent was sought before care and treatment were provided. A recent medication error was rectified promptly, and the patient had not been affected. There was openness and transparency when things went wrong, and information had been cascaded down to frontline staff following multidisciplinary meetings.

Staff knew how to raise concerns and make safeguarding referrals. Some staff had knowledge of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. The wards were clean and uncluttered. Equipment was appropriately checked and cleaned, and had been serviced regularly to ensure that it was working effectively.

Incidents

- No 'never events' or serious incidents had been reported for medical services in the period from December 2012 to January 2014. ('Never events' are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.)
- All staff we spoke with said that they were encouraged to report incidents. There was openness and transparency when things went wrong. Themes from incidents were discussed at weekly safety meetings.
- Staff were able to give us examples where practice had changed as a result of incident reporting. For example, there was a near miss medication error, described below under 'medicines'. The error was discovered the same day and the patient was not affected. Staff were reminded to be extra vigilant, and appropriate action was taken by the trust. We spoke with two members of staff the day after the incident and they were aware of the incident.

Safety thermometer

- The service used the NHS patient safety thermometer to support the provision of safe care.
- The scores were all on display on the notice board. In Gladstone 1, for example, there had been three reported falls, but all other indicators scored 0. Records showed that there had been no hospital-acquired pressure ulcers on Gladstone 1 for over two years.
- Nursing key performance indicators (KPI) were tabulated monthly and displayed.

Cleanliness, infection control and hygiene

- All the ward areas were clean and tidy.
- Separate hand washing basins and hand gel were available in all of the wards. We observed staff washing their hands and using antibacterial hand rub in-between contact with patients, and on entering or leaving the bays within the wards.
- Personal protective equipment (PPE) (gloves, aprons, etc.) was available for use by staff in clinical areas. We observed staff wearing PPE when required.
- Staff wore clean uniforms with arms 'bare below the elbow' as required by the trust's policy.

Environment and equipment

- The wards were clean and uncluttered. Audits showed that this was the norm, and patients and staff also confirmed that this was the case.
- There was adequate equipment on the wards to ensure safe care. Equipment was appropriately checked and cleaned, and had been serviced regularly. In Gladstone 1, for example, the equipment in use was visibly clean and dust free, and some had been labelled with the date it had been cleaned. The ward kept a record of the 'weekend cleaning' of equipment. Broken equipment was labelled and reported to the maintenance department for repair.
- The resuscitation trolleys in the wards were checked daily by a designated nurse, and appropriately recorded. Records were seen for the last two months.

Medicines

- In Gladstone 4, we were told that on 21 May 2014 there had been a medication error. This had occurred because a nurse had attached the wrong name label to a patient's medicine chart. This had been discovered two hours later and rectified. The incident was reported on the electronic incident reporting system. The ward manager confirmed that the patient involved was not affected.
- We saw a pharmacist auditing the stock medicines before restocking them. This was done on a daily basis. We were told that a second pharmacist would prepare all the medicines for patients who would be discharged on the day.

Medical care (including older people's care)

Records

- Patients' records had been maintained by staff within the medical department. We looked at 16 patients' care notes and observation charts, and found them detailed and appropriately maintained. In the acute admissions unit (AAU), five patients' medical notes and drug charts were checked, and they were found to be detailed and well completed.
- We observed that standard risk assessments for patients had been undertaken, such as the risk for patients prone to falls, Waterlow scores for pressure areas, and the malnutrition universal screening tool (MUST) score for nutrition. Records showed that these assessments were carried out on admission, and reviewed when the patient's condition changed, or weekly as a minimum.
- All patients' clinical notes in paper format were kept in lockable trolleys within the nurses' station. Confidential information was stored securely, and notices were displayed at nurse's stations to remind staff not to leave patient records on the desk unattended.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients confirmed that their consent had been sought prior to treatment. They described how procedures had been explained to them by both nurses and doctors. We saw patients' signatures of consent in the records we checked. Staff told us that they had always asked patients for their consent before carrying out personal care.
- In Gladstone 1, we saw two 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms, which had been completed and signed by the consultant, and it was documented that relatives had been involved in the decision.
- The ward manager in Gladstone 4 confirmed that there had been no patients subjected to the Deprivation of Liberty Safeguards (DoLS). We found that staff in Gladstone 1 had knowledge of the Mental Capacity Act (MCA), (2005) and the DoLS application process. Staff stated that they would contact senior practitioners if they had any concerns about a patient's welfare. No staff were aware of any applications made under DoLS, or the use of independent mental capacity advocates (IMCA).

Safeguarding

- All the ward staff knew who the safeguarding lead was for the trust. They could articulate what constituted abuse and how to raise concerns.
- We were told that all safeguarding referrals had been completed on time. During the inspection we witnessed a safeguarding referral being made promptly.

Mandatory training

- Staff told us that staff had received mandatory training, including MCA (2005) and DoLS, safeguarding vulnerable adults, infection control, and moving and handling.
- In Gladstone 4, we found staff had received other training on topics such as delirium and dementia, given by the consultant psychiatrist. Staff had also received training on learning disability.
- Junior doctors reported that there was a good teaching timetable and that most of the time they were able to attend the teaching sessions. Medical trainees did not undertake training with other healthcare professionals.

Management of deteriorating patients

- There was an escalation protocol available to ensure that patients received appropriate medical attention. Medical staff were based on the ward during the day, and a site practitioner was available out of hours. Staff told us that they would not hesitate to escalate a concern to the consultant if they needed to.
- The medical service used the national early warning score (NEWS) charts, which gave staff directions for escalation. We case-tracked a patient's care records in Gladstone 4, and observed that the NEWS chart was in use as the patient's condition had deteriorated following admission. There were clear observations and the NEWS recording charts had been appropriately completed. Repeated observations had been made within the necessary timeframe.
- Staff we spoke with had knowledge of the appropriate action to be taken if a patient's NEWS score was elevated. A senior manager confirmed that the NEWS records had been regularly audited.

Nursing staffing

- The head of nursing and the ward manager for Gladstone 1 confirmed that staffing had been reviewed. As a result, the staffing level had been increased so that the needs of patients could be met.
- The ward's quality board listed the numbers of staff on duty, both actual and planned. Staffing was adjusted to

meet the needs of patients. We observed that staff had been brought in to support patients with additional needs; for example, increased observation for a patient who had fallen, or for a patient who was confused.

- We were told that Gladstone 4 had eight vacancies for five staff nurses and three healthcare assistants (HCA). The ward manager told us that the trust had advertised these posts and recruitment was in progress. In the meantime, agency and bank staff had been utilised to make up the numbers. We were told that regular agency staff had been used to ensure continuity of care for patients.
- In Gladstone 4, the ward manager confirmed that the staffing numbers and skill mix were adequate, using agency or bank staff to make up the numbers when required. The ward manager was present on the day of the inspection, to supervise and manage the ward.
- Handovers were carried out in stages. The nurse in charge (NIC) gave a handover in the office. This was followed by a bedside handover that involved the patient. There was also a ward board handover with members of the multidisciplinary team (MDT).

Medical staffing

- Doctors were available 24 hours a day. There was consultant cover seven days a week, including at night. There was appropriate cover by junior and middle grade doctors on the wards, day and night. The medical director visited the wards every morning and was very much involved.
- Consultants were supported by specialist registrars and junior doctors.
- Junior doctors were based on the wards and were readily available to attend to patients when required. They felt that they received good training, had a good relationship with consultants, and were well supported. They had time to attend teaching sessions and had been involved in audits.
- Some junior doctors felt that they had not been getting adequate training in governance and that they were not always given feedback from incidents reported.
- Medical handovers between the night team and the day team took place in the morning, during which a consultant was present.
- Doctor's ward rounds took place daily.

Are medical care services effective?

Good

Care and treatment were provided in accordance with evidence-based national guidelines. Staff ensured that the medical, psychological and personal care needs of patients were met appropriately. This included good pain relief, nutrition and hydration.

There had been formal weekly multidisciplinary team meetings, where patients' conditions and treatment, complaints and concerns had been discussed, and where decisions had been taken to improve patients' care.

Evidence-based care and treatment

- The hospital's protocols were based on the National Institute for Health and Care Excellence (NICE) guidelines. Local policies were written in line with this. Staff knew where to find policies and local guidelines, which were available on the intranet.
- For 2012/13 the trust participated in all but three of the 40 national clinical audits for which it was eligible.
- Central Middlesex Hospital participated in the Myocardial Ischaemia National Audit Project (MINAP). The hospital was rated as within expectations or better than expected in two of the MINAP indicators, and worse than expected in one indicator.
- Central Middlesex Hospital's performance was found to be within expectations for 16 of the 19 indicators in the 2010 falls and bone health audit for older people.

Pain relief

- In Gladstone 4, we observed staff administering medicine to a patient for pain relief. The pain was in the patient's leg, which staff also elevated to allay discomfort. The patient had expressed relief from the pain following this helpful response from the staff.

Nutrition and hydration

- Patients were referred to the dietician to ensure that their nutritional intake was sufficient. Supplementary feeding was arranged as needed, and records showed when naso-gastric or gastrostomy tubes were inserted.
- Patients commented that there was a choice of menu and the food was 'excellent'.
- A relative was pleased that their parent was provided with cultural dishes at meal times.

Medical care (including older people's care)

- We observed jugs of water by each patient's bed. Staff gave patients assistance and encouraged them to drink when appropriate.
- We observed staff checking patients on intravenous infusions, and fluid balance charts had been maintained.

Patient outcomes

- The SSNAP allows comparison of key indicators that contribute to better outcomes for patients. Overall performance was rated from A (highest, which no service achieved) to E.
- It was acknowledged by the audit that very stringent standards were set. Data from October to December 2013 showed that the trust performed well and achieved a grade C overall.
- The trust's performance was rated as within expectations or better than expected for four of the MINAP indicators.
- In the National Diabetes Inpatient Audit 2013 the trust were worst that the national average for the number of hours a week that the specialist team providing care. This included nurse, consultant, dietician, podiatrist and pharmacist hours which were all below the national average. Whilst emergency admission rates are higher than the national average the actual number of patients admitted for diabetes as the primary reason is small and below average.
- The clinical site practitioner confirmed that there had been very few patient readmissions within 28 days as per the target set.

Competent staff

- Team leaders carried out the appraisals for nursing staff, identified training and development needs, and maintained records of staff training. The e-rostering system issued alerts when mandatory training was due. Ward meetings and handovers were used to discuss issues and concerns.
- Staff reported that they had attended induction on starting employment, and had attended mandatory training. They reported that they were supported to gain new skills and had opportunities to attend courses when they were advertised.
- In Gladstone 4, we were told that the majority of the nurses had received training on cannulation and phlebotomy. There were mentoring arrangements for newly appointed junior nurses.

Multidisciplinary working

- There was evidence of multidisciplinary working within the department, with other services within the trust, and with external organisations. For example, two consultants who specialised in neuro-rehabilitation have wards in local community hospitals.
- There were good shared-care arrangements with surgeons from Northwick Park Hospital. For example, Gladstone 4 received orthopaedic patients requiring rehabilitation from Northwick Park Hospital.
- Sometimes patients were placed in an inappropriate ward because of the shortage of beds. When this happened, doctors said that they sometimes had difficulty in contacting the staff team on the other ward.
- The bed manager confirmed that there were daily video-linked bed management meetings held with Northwick Park Hospital to facilitate patient transfers.
- In Gladstone 4, there was a multidisciplinary team (MDT) meeting every Tuesday, which involved the consultant and their deputy, the occupational therapist, the physiotherapist and the discharge co-ordinator.
- There were daily and weekly ward rounds carried out by the MDT.

Seven-day services

- There was 24 hour cover, with one registrar supported by three junior doctors. Other registrars were on-call after 5pm. On-call out-of-hours cover was provided by consultants after their last ward round. There was an anaesthetist on site 24 hours a day.

Are medical care services caring?

Good

Patients, and those close to them, were complimentary about the way that staff cared for them, and they felt respected by staff. Patients felt involved in decision-making about the care, support and treatment that they received.

Psychological support included a referral to a specialist psychiatrist if required. Clinical nurse specialists were available in various disciplines, such as end of life care and dementia.

Compassionate care

- The Friends and Family Test result indicated that people would recommend the hospital.

Medical care (including older people's care)

- The wards in Gladstone 1 and 4 were divided into four, four-bedded bays with eight en suite single rooms. There had been no breaches of the same sex accommodation policy, and there were designated gender-specific bathroom facilities.
- Staff respected patients' privacy by closing the curtains around their beds when appropriate, and they were observed to ask each patient for permission to enter. Call buzzers were answered promptly. Patients reported that staff were always available when needed, and that they did not have to wait long for buzzers to be answered.
- Patients were complimentary about the staff from every discipline. Comments received included, "Staff are very good; when I need them, I use the buzzer and they come in straight away" and "staff are polite and helpful".
- We observed that staff had warm, professional and caring conversations with patients, who were overheard laughing and joking with staff.

Patient understanding and involvement

- Patients felt that they had been involved in their care and treatment. They felt well informed before they signed the consent form for treatment. Comments received included, "they are doing their best", "both doctors and nurses keep us informed" and "the doctor explained things to us". However, there was one patient who felt that the doctor had not discussed their care with them.
- There was a good range of information leaflets available, and they had been updated regularly.
- Patients were allocated a named nurse for each shift. The name of the consultant was displayed on a bedside board. We noted that patients knew the names of the staff.

Emotional support

- We were told that in the case of long-term patients who required emotional support, the medical team had made referrals to the specialist psychiatrist from a nearby hospital.
- In Gladstone 4, relatives of one patient were supported by staff when they expressed concern about their parent's potential discharge to their own home. Action taken by the staff had allayed their anxiety, and placement to a nursing home had since been arranged with all parties involved, including social services.

Are medical care services responsive?

Good

People were able to access medical services in a way that was convenient for them. However delays were experienced by patient's treatment when a surgical consultation was required. The staff had received appropriate training to meet the needs of the community, including equality and diversity, and dementia training.

The service maintained good communication and relationships with local GPs and other healthcare providers. This had ensured that patients received continuity of care when discharged from the hospital.

Service planning and delivery to meet the needs of local people

- The coronary care unit (CCU) was designed so that it could be used as a chest pain assessment unit. It was also used as a step down facility from Northwick Park Hospital.
- The process for moving patients to and from Northwick Park Hospital worked very well.

Access and flow

- There was a good flow of patients through the hospital, whether day case or inpatient, through to discharge. However due to the lack of surgeons within the hospital when there was a cross referral delays could be experienced by patients.
- In Gladstone 1, outliers were accommodated on the ward. Staff worked with the site practitioners to ensure that patients were placed on appropriate wards.
- When a patient was discharged, a discharge summary was sent automatically to the GP by email. This detailed the reason for admission, the results of any investigations, and the treatment that the patient received.
- There was a discharge lounge available where patients could wait for transport, and this freed up beds for new admissions. The discharge lounge was open from 9am to 6pm, and was staffed by a nurse. There were facilities available to provide drinks and snacks. A register was kept of patients brought to the lounge.
- The discharge co-ordinator reported that they monitored delayed discharges. We were told that there were approximately 30 per week.

Medical care (including older people's care)

Meeting people's individual needs

- Staff had received appropriate training to meet the needs of the community, including equality and diversity, and dementia training. As a result, they were able to care for people with dementia. They could seek advice from the dementia lead, and could access e-learning. Literature was on display to inform staff of types of dementia, and how they should care for people with dementia.
- Staff employed were from multi-ethnic backgrounds, which reflected the local population.
- Translation services were available for patients when appropriate, via a contracted provider.
- Discharge co-ordinators were allocated to the wards to assist with complex discharges. Families and carers met with the multidisciplinary team (MDT) to discuss discharge arrangements.
- The ward manager was involved in arranging 'normal' discharges, and ensured that appropriate referral forms were completed and sent to the local authority. We saw the discharge care planning documentation being completed by staff and arrangements confirmed.
- The ward manager and the matron did ward rounds to pick up any issues from patients. Many 'thank you' cards were on display, and the staff kept a record of those received.
- Staff supported patients with physical, mental health and cultural needs.
- In Gladstone 4, we observed that cultural-specific food and drinks were provided by the ward for patients. We noted that the English interpretation of a foreign language was on the wall by the bed of a patient in order to aid staff in communicating with them.
- The psychiatric liaison nurse from another trust would review a patient if referred by a doctor.

Learning from complaints and concerns

- Staff confirmed that the ward manager had discussed at staff meetings any concerns or complaints raised and the lessons learned.
- Issues discussed at MTD meetings that were attended by managers were fed back to staff at local staff meetings.
- There was information displayed on the wards about how to provide feedback on the service patients had received, and how patients and relatives could make a complaint.

Are medical care services well-led?

Good

The medical service had clear line management arrangements. Staff were well supported by the trust's medical director, who visited Central Middlesex Hospital on a daily basis.

The consultant-led team of medical staff held clinical, audit, mortality and morbidity meetings. Senior clinicians were visible and approachable, and staff told us that they listened to them.

Systems were in place for clinical governance. There was a risk register for the directorate, and risk management issues were discussed at directorate meetings, held every two weeks.

Vision and strategy for this service

- Staff were aware of the names of the chief executive and the medical director, both of whom were very well respected. There were pictorial board structure posters displayed throughout the hospital, but staff were unable to recall the names of other board members.
- Staff told us that the chief executive had held open forum meetings to update them on the proposed closure of the A&E department, and the trust merger with Ealing Hospital NHS Trust.
- Staff had been sent daily emails and the chief executive's bulletin to update them on trust developments. Some staff reported that they did not always read those updates.

Governance, risk management and quality measurement

- The consultant-led medical staff team held clinical, audit, mortality and morbidity meetings.
- Risks were identified and escalated to middle managers. Ward managers did not maintain a risk register for their area of responsibility. There was a directorate risk register with each risk red, amber, green (RAG) rated. This was discussed at directorate meetings, which were held every two weeks.
- Systems were in place for clinical governance. Incidents were reported through an electronic incident reporting system. However, they were not always marked as

'closed' on the system when they had been dealt with. A new clinical governance manager had started work recently in order to ensure more robust monitoring of risk.

- The quality board showed that there had been a 50% reduction in ward team sickness rates. The head of nursing reported that 32 staff members had been performance-managed at Central Middlesex Hospital. The ward manager made calls to staff on sick leave to enquire about their welfare, and to remind them to submit their sickness certificates.

Leadership of service

- There were clear line management arrangements. Staff knew the matron, head of nursing and the general managers of the directorate. They told us that the matron and head of department were very visible on the units, and that they could approach them about anything.

Culture within the service

- Staff reported they did not know very much about the staff survey, and no one was aware of bullying and harassment issues. Staff were unanimous in saying that they would report such incidents. Staff expressed great confidence that the senior management of the directorate would address any concerns highlighted.
- Staff told us that the medical director visited the hospital daily, and that senior clinicians were visible and approachable.
- Staff were uncertain about the future of their service following the closure of the A&E department in September 2014.
- Consultants at Central Middlesex Hospital felt disconnected from the Northwick Park Hospital site.

Public and staff engagement

- Patients, and those close to them, gave positive feedback about the care and treatment that they received.

Innovation, improvement and sustainability

- Doctors had raised an issue with the consultants concerning the inappropriate handover of patients on Friday afternoons. As a result, improvements had been made, and a screening process was now in place to ensure that all jobs were handed over appropriately to ensure patient safety.

Surgery

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

Information about the service

Central Middlesex Hospital undertakes elective surgery only, including day cases. They are based around Abbey Ward, which also includes care for specialist orthopaedic patients and has a total of 24 beds.

Summary of findings

Surgical services provided safe and effective care in the areas we visited. There were appropriate numbers of nursing and medical staff, and staff followed guidance when providing care and treatment.

Staff were caring and supportive of patients, and made efforts to keep them involved in decisions about their care and treatment.

Arrangements were in place to accommodate the different religious and cultural needs of patients. There was usually a suitable flow of patients through the department. However, there were isolated issues relating to inadequate pre-assessments prior to patients being admitted to the department.

There were suitable arrangements in place to monitor the quality and safety of the service.

Surgery

Are surgery services safe?

Good

Surgical services provided safe care to its patients. There were appropriate numbers of nursing and medical staff. Policies and procedures were in place to ensure that patients were kept safe whilst on the ward and undergoing surgery. Staff undertook checks to make sure that these procedures were adhered to.

Incidents

- Between December 2012 and January 2014 four 'never events' took place at the trust. This was considered to be within the acceptable range. All four of these related to surgical services.
- Staff were able to describe the changes that had been made to the way they worked as a result of the review of incidents. We saw records of multidisciplinary committee meetings where incidents were discussed, including causes and how they would be prevented in the future.
- In addition, the department reported 35 incidents to the National Reporting and Learning System (NRLS). Of these, 24 were classified as 'moderate', three as 'abuse', four as 'severe' and four were deaths.
- Staff were aware of how to escalate incidents within their own wards using the electronic incident reporting system.
- Morbidity and mortality meetings took place on a monthly basis.

Safety thermometer

- The department used a safety thermometer to monitor the safety of the services it was providing. The performance of the department between April 2013 and March 2014 was rated positively, at 98.35% harm-free. Results were collected for each ward, so that isolated episodes of poor performance could be highlighted.

Cleanliness, infection control and hygiene

- During our inspection all areas that we saw were clean and tidy. Hand washing facilities, sinks and personal protective equipment were available throughout.

Environment and equipment

- Appropriate emergency drugs and equipment were available throughout the department. Regular checks were made on these to ensure that they were in date, and in good working order.

Medicines

- All medicines were stored in a secure manner that was accessible only to staff. Records were kept of what medicines had been administered.

Records

- We reviewed patient records across the department, and they showed that basic information and risks assessments were appropriately completed. Patient observations were up to date. Details of daily multidisciplinary team (MDT) meetings were included, as was discharge data.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received mandatory training in consent, the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.
- There were specific forms to be completed when a person was unable to consent to surgery that indicated the reasons that this was the case.
- In the records we reviewed, patients' consent to surgery was appropriately completed.

Safeguarding

- There was a safeguarding policy and procedure in place.
- Staff received mandatory training in safeguarding vulnerable adults, though take-up of this training was variable across the department.
- There was an internal trust safeguarding team to whom staff could report concerns.

Mandatory training

- The trust kept a record of mandatory training completed by staff within the surgical department. Whilst a satisfactory range of topics were covered, including basic life support and infection control, the information provided showed variable rates of completion of this training across the department.
- It was noted that whilst some staff had received basic life support training, not all staff had been trained to use the defibrillators on the resuscitation trolleys.

Surgery

Management of deteriorating patients

- The World Health Organization Surgical Safety Checklist was used by the department to ensure that patients were safe prior, during and after surgery. Recent audits of the completion of this did not highlight any risks within the department.
- The department used an early warning scores system to monitor the ongoing condition of patients. In recent audits most wards scored highly in terms of their use of this tool.

Nursing staffing

- Senior staff reported that they used the 'Hurst' workforce planning tool, as well as a recently commissioned report by an external company, to decide on the nursing levels and skills mix of nursing staff that they needed on each ward.

Medical staffing

- Some staff reported that surgical doctors mainly attended promptly when requested, although others said that it could be difficult to get hold of them on some occasions.

Major incident awareness and training

- There was a major incident policy and procedure in place.
- Staff had training in what to do in the event of a major incident.

Are surgery services effective?

Good

Staff followed appropriate guidance when providing care and treatment. They were suitably trained for their roles, and worked well with other professionals and departments. Senior staff were available throughout, and audits were undertaken to monitor the quality of outcomes for patients. However, patients were not always assessed appropriately at Northwick Park Hospital, which led to delays in care being provided.

Evidence-based care and treatment

- There was a team of consultants who sent out bulletins each month on any new National Institute for Health and Care Excellence (NICE) guidelines that had been published. In addition, specialist nurses (such as Tissue Viability Nurses) provided specific guidance to staff on any development in their fields. New developments were discussed at handovers.
- Standard risks assessments were used to evaluate patients, and ensure that they were safe whilst within the department. These included the Waterlow assessment to check for risks of pressure ulcers, and the MUST nutritional screening tool. There were also specific assessments, undertaken to ensure that patients were fit and well enough to undergo surgery, which followed national guidelines.

Pain relief

- There were specific policies on pain relief within the trust. Staff reported that post-operative pain was discussed with patients during the pre-operative stage.
- Prescribing nurses had specific assessment tools and guidance they could use to provide pain relief to patients in the absence of medical staff.
- Comprehensive patient group directions (PGD) were available to nursing staff, about pain relief and medicines they could provide to patients. These were reviewed on a regular basis.

Nutrition and hydration

- Patient records we reviewed at the hospital showed that nutritional assessments and fluid balance charts had been completed correctly.

Patient outcomes

- Staff told us that some patients they received, who had been pre-assessed at Northwick Park Hospital, had not undergone an appropriate assessment and were admitted with additional medical conditions that had not been identified during the assessment. This resulted in their surgery having to be delayed whilst they underwent appropriate pre-operative assessment, preparation and treatment on the main ward.

Competent staff

- The trust was actively recruiting nursing staff from overseas in order to fill vacancies. Once recruited, they were given time to adjust to the NHS, and there was a specific induction course for them to complete.
- Nursing staff had access to mentorship programmes. They had annual appraisals with six monthly reviews. They had supervision, where senior staff assessed their clinical work and provided feedback to them.

Surgery

- Staff reported that the use of medical locums at the weekend could be problematic, as not all of them had access to the computer system, and so needed another doctor to be present when they used it.
- There were concerns that the volume of work for specialist registrars would hamper their ability to deliver training to more junior doctors.

Multidisciplinary working

- Multidisciplinary team working was evident. Allied healthcare professionals, such as physiotherapists and radiological staff, were available on request. However, some staff across the department reported delays in getting radiological assistance in some cases (such as for ultrasounds).

Are surgery services caring?

Good

We observed positive interactions between patients and staff. Staff were caring and supportive of patients, and made efforts to keep them involved in decisions about their care and treatment. However, some patients expressed concerns that medical staff did not explain things to them in as much detail as they would have liked.

Compassionate care

- We spoke with ten people using the service across the hospital. They told us that they were happy with their treatment, and the way that they had been looked after. Nurses were described as "caring" and "helpful".
- We observed numerous examples of patients being treated with care and consideration. Their privacy and dignity was respected, with curtains being drawn around their beds when appropriate.
- In the Friends and Family Test undertaken in February 2014, none of the surgical wards scored lower that the trust average for patients who would recommend the service.

Patient understanding and involvement

- Staff provided written information to patients pre-operatively on how to prepare for procedures.
- One patient told us that they had been provided with an explanation of their condition and treatment by staff.
- The main ward ran workshops for future orthopaedic patients that covered what their treatment and recovery would involve.
- Some patients said that their time with medical staff had been brief, and they did not feel that they had received full explanations of their condition/treatment. In addition, staff noted that the main issue raised in complaints across the trust was usually a lack of, or poor communication with, patients.
- All nursing staff that we observed wore name badges.

Emotional support

- Staff had access to the bereavement services within the trust, as well as different religious persons, should patients/relatives/carers require such support.

Are surgery services responsive?

Good

Surgical services were responsive to people's needs. There were plans in place to deal with increases in the volume of patients being seen at Central Middlesex Hospital. Arrangements were in place to accommodate the different religious and cultural needs of patients. There was usually a suitable flow of patients through the department. However, there were isolated issues relating to inadequate pre-assessments prior to patients being admitted to the department. This meant that on some occasions, it would be over 24 hours between patients' admission and their procedure, resulting in blockages to the system.

Service planning and delivery to meet the needs of local people

- The department operated a winter plan to increase their resources across the winter months to account for the greater volume of patients.

Access and flow

- Inadequate pre-admission assessment at Northwick Park Hospital resulted in patients being admitted to the main ward at Central Middlesex Hospital for extended periods prior to their procedure to undergo appropriate assessment, pre-operative treatment and preparation.
- Staff reported that on some occasions, beds were removed by the trust, which made appropriate admission planning difficult.

Surgery

- Discharge planning started pre-admission or on admission, and involved numerous professionals, including occupational health and social services where appropriate. Discharge plans were monitored as part of the daily handover.
- There was a specific risk assessment to be completed before patients were discharged. This looked at what the needs of the patient were, the plans needed to be made, and the resources to be put in place before they were discharged.

Meeting people's individual needs

- There were a range of food options to meet people's cultural or religious needs.
- Translation services were available if people need them, but staff would also utilise their colleagues who could speak different languages.
- Staff received training in caring for and treating people with dementia.

Learning from complaints and concerns

- There was a process in place for the receipt, investigation and feedback on complaints.
- Staff reported that they received complaints, as well as positive patient feedback.

Are surgery services well-led?

Good

Local leadership was good, as staff described a supportive team environment. There were suitable arrangements in place to monitor the quality and safety of the service. However, while staff were aware of the performance of the department, they were unclear as to when the trust would take action to address any issues. There were widespread concerns about the future of the department and support services, given the developments within the hospital as a whole.

Vision and strategy for this service

- Whilst staff had an idea of the performance of the department, where improvements were needed, and the general plans for making them, staff were not clear on how or when these improvements would be made.
- A large proportion of staff were concerned about the future of the hospital in general, as well as the safe functioning of the department with the ongoing loss of services from the hospital.

Governance, risk management and quality measurement

- The department collected suitable information on both the safety of the service, and the quality of outcomes of treatment.
- There were regular meetings of senior staff, both nursing and medical, where performance was discussed and plans made to address any issues.

Leadership of service

- Senior staff spoke positively about the current senior management within the trust, and said that they retained the confidence of senior medical staff.

Culture within the service

- Staff that we spoke with, at all levels, described friendly and supportive relationships within the surgical services team. However, numerous staff remarked on the pressure that they and their colleagues were under.

Public and staff engagement

- The department used the Friends and Family Test in order to obtain feedback from patients and relatives. However, aside from this and the spontaneous feedback provided by patients and their families, the department did not employ a method to obtain systematic in-depth feedback on the quality of the service they were providing.

Critical care

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

Information about the service

Critical care at Central Middlesex Hospital is comprised of a four bed intensive treatment unit (ITU) and a four bed high dependency unit (HDU). Both planned admissions from the surgical and medical teams, as well as emergency admissions from the A&E department, are admitted to the units.

Summary of findings

The critical care services at Central Middlesex Hospital require improvement. There were appropriate numbers of suitably-trained staff, who worked according to procedures to keep people safe. Staff collected ongoing data on the safety and performance of the department, which indicated positive patient outcomes.

Staff were caring towards patients, and were able to respond to fluctuations in demand. However, governance arrangements could be improved, as could the strategy and vision for the department as a whole. Whilst morale within the team was positive, it was not clear how the unit linked with the trust-wide department as a whole.

Critical care

Are critical care services safe?

Good

Staff actively monitored the safety of the service and responded to any incidents or low performance figures. The environment was appropriate for the care and treatment carried out, and there were appropriate numbers of suitably-qualified staff.

Incidents

- Between December 2012 and January 2014 five serious incidents took place in intensive care / high dependency units within the trust as a whole, and these were reported to the Strategic Executive Information System (STEIS). Between February 2013 and March 2014 four incidents were reported to the National Reporting and Learning System (NRLS), all of which were given a rating of 'moderate' severity.
- There was a procedure in place for incidents to be reviewed and learning taken from them. Appropriate staff were kept up to date with the outcomes, and any relevant changes to practices or procedures.
- Staff reported that mortality and morbidity meetings did not take place on a regular basis. We were told that deaths were discussed at weekly multidisciplinary meetings. However, these did not constitute an in-depth review of the circumstances of the death, and if any learning could be taken from them.

Safety thermometer

- Staff monitored the safety of the department using a 'safety thermometer', whereby the number of falls and pressure ulcers (amongst other indicators) where monitored. At the time of the inspection, no significant safety issues were highlighted by this tool. The results were displayed within the critical care unit.
- In addition, staff reported on data that was collected from numerous other sources to assess the safety of the service. This included data from patient notes and their daily records. These results were analysed, and staff told us of specific improvements that had been driven by this process, for example, improvements in the mortality rate and the number of days that patients were on ventilators.

Cleanliness, infection control and hygiene

- Staff reported that infection control audits took place on a regular basis and we saw evidence of this. This included monitoring the number of healthcare-associated infections of patients, as well as compliance with hand washing protocols and the general cleanliness of the department's environment. We reviewed this data and noted that no significant issues were raised with the cleanliness of the environment.
- Clinical areas we visited were clean and tidy. We observed staff adhering to infection control policies and procedures, such as the use of personal protective equipment and hand washing.
- However, the infection control policy was not readily accessible to all staff.

Environment and equipment

- Emergency equipment and drugs for resuscitation were available throughout the department, and there were checks on these to ensure that they were in good working order and in date.

Medicines

- Medicines were securely stored and were accessible only to authorised staff.

Records

- We reviewed a selection of patient records. All had appropriate risk assessments completed, such as nutritional and pressure ulcer risk assessments.
- Clinical observations and medication administration records were complete and up to date.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff undertook mandatory training in consent, the Mental Capacity Act and Deprivation of Liberty Safeguards.

Safeguarding

- Staff undertook mandatory training in safeguarding vulnerable adults. There were guidelines and protocols about how staff should act on any concerns identified within the critical care unit.

Mandatory training

- Staff undertook mandatory and refresher training on a regular basis, in appropriate topics including basic life support and infection control.

Critical care

- Most staff were up to date with their mandatory training. The management was aware of the staff members whose training was out of date and overdue for an update.

Management of deteriorating patients

- The department used the national early warning scores (NEWS) system to alert them to when a patient's condition may be deteriorating.
- There was a specific policy in place covering the management of deteriorating patients, which included details around observation and monitoring, as well as clinical responses. This was written in March 2013 and had been scheduled for review in March 2014.

Nursing staffing

- Nursing levels were based upon the Royal College of Nursing and the British Association of Critical Care Nurses guidelines.
- There was a high proportion of senior grade nurses (65% at band six or seven), with 35% at band five.
- We looked at previous rotas which confirmed that the planned nursing staff levels were maintained over time.
- The nursing staff that we spoke with said that they were well supported on the unit.

Medical staffing

- There were appropriate numbers and grades of medical staff for the number and acuity of patients on the units. We looked at previous rotas and noted that these numbers and mix had been sustained over time.
- However, it was noted that on some days, there were no trainees present, and the department was reliant on the use of locums on other days.
- The units were covered by the anaesthetic resident out of hours.
- An outreach team operated throughout the hospital 24 hours a day, five days a week, and 12 hours per day at weekends.
- There was difficulty obtaining a surgical consultation.
- There was a lack of imaging services at the weekends.

Major incident awareness and training

- There was a major incident policy and procedure in place.
- Staff had training in what to do in the event of a major incident.

Are critical care services effective?

Requires improvement

The unit, whilst undertaking some local audits, such as the NW London audit, were unable to identify through standardised audit areas for improvement and performance management. There were some mechanisms and audits to monitor the quality of treatment outcomes. Staff worked well with each other and other departments within the hospital. There was appropriate guidance for nursing staff, although very little was available for medical staff, and this was an issue across the trust.

Evidence-based care and treatment

- Staff used the national early warning scores (NEWS) system to monitor the condition of patients. They used industry-standard risk assessments, such as the Waterlow pressure ulcer tool and the MUST (Malnutrition Universal Screening Tool).
- There were trust-wide policies available on the intranet, which provided general guidelines on providing nursing care, and these were mainly up to date. However, there were very few protocols for medical staff. For instance, there were no protocols on important aspects of critical care such as sedation, management of septic patients, or renal replacement therapy. This posed a risk of inconsistent or inappropriate care and treatment of patients. In addition, because these protocols were not in place, senior staff were very limited in what treatment they could delegate to junior medical staff to carry out, and had to treat patients themselves.
- Nursing and medical staff undertook audit work looking at the outcomes of care and treatment for patients using the NW London audit tool. The information gathered did not indicate any significant issues. However, it was noted that a large proportion of this information was gathered using a local tool, and was not benchmarked against national data such as the ICNARC programme. At the time of the inspection, information was not available about how the trust rated against the other local trusts that used this tool.

Pain relief

- There were written protocols for nursing staff on the provision of analgesia for the alleviation of patients' pain.

Critical care

Nutrition and hydration

- We reviewed the records of six patients across the trust. Nutrition and hydration risk assessments had been completed were appropriate. Fluid balance charts were recorded on a daily basis and there were daily nursing evaluations of nutrition and hydration. Records showed that a dietician was involved when appropriate.

Patient outcomes

- Recent audits of the performance of the department between March 2013 and January 2014 showed that patient outcomes were positive in most areas, including late night discharges, readmissions within 48 hours, and length of stay.

Competent staff

- Nursing staff begin working in the department as supernumerary for the first month, so that they could learn about the department. Staff were supervised on a regular basis.
- The nursing staff members that we spoke with said that they felt well-supported.
- Medical locums were used extensively throughout the department. Not all locums had access to the computer system, so they were reliant on other medical staff being present for some of their duties.

Multidisciplinary working

- Multidisciplinary team (MDT) meetings took place on a weekly basis. These would feature consultants, ITU trainees, the microbiologist and nursing staff, as well as other relevant healthcare professionals. Staff reported that they would also try and link to the Wednesday MDT at Northwick Park Hospital.

Are critical care services caring?

Good

We observed positive interactions between patients and staff. Patients were treated in a caring manner and involved in decisions about their care and treatment when possible.

Compassionate care

- Throughout the inspection we saw patients and their families being treated in a kind and considerate manner by staff members.
- Three patients told us that they were very satisfied with the quality of care that they received at the critical care facilities at Central Middlesex Hospital.
- Patient's dignity and privacy was respected throughout, with curtains being drawn around cubicles when personal care and treatment was being provided.

Patient understanding and involvement

- There were written records of family members being involved in the planning of, and decisions about, patients' care and treatment.
- In one record we reviewed, staff had documented the discussion they had had with a patient's family about resuscitation.
- We observed a ward round where staff discussed care and treatment plans with patients.

Emotional support

- Staff had access to the trust's bereavement services, as well as a range of religious persons.

Are critical care services responsive?

Good

Access to the department and flow through it were positive. People's individual needs were met, and the critical care units at Central Middlesex Hospital could help to meet the increased demand for beds at Northwick Park Hospital.

Service planning and delivery to meet the needs of local people

- There was a policy and procedure in place for the units to accept transfers from other local facilities, in particular Northwick Park Hospital, and this occurred on a regular basis.

Access and flow

- Audit information relating to this hospital showed that the critical care units were scoring well in terms of patients' length of stay, a lack of night discharges, and a lack of re-admissions within 48 hours. These factors indicated a positive patient flow through the department.

Meeting people's individual needs

- The service had access to translators if needed, and these were advertised on the units.

Critical care

- Following their discharge, all patients who had stayed in critical care for three days or more, were invited to attend up to three follow-up outpatient appointments, to check on their progress.

Learning from complaints and concerns

- There was a policy and procedure in place for the recording, investigation and responding to of complaints.

Are critical care services well-led?

Requires improvement

There was a lack of vision or strategy for the entire team, and leadership from the overall trust was lacking. There had been no clinical lead for the service which impacted on the direction for the service. Medical staff complained of the lack of supervision. There were arrangements in place to manage the day-to-day operation of the units, and to make sure that patients were safe. Morale and leadership within the team was positive. All staff were concerned for the future of the hospital as a whole.

Vision and strategy for this service

- There was no overall strategy or vision in place for critical care services. It was noted that there had been no clinical lead since March 2014, the lead at Northwick Park Hospital had been covering, but staff reported that one had been appointed in the week prior to our inspection.

Governance, risk management and quality measurement

- There were systems in place for governance, risk management and quality measurement within the department. There were specific data items that needed to be collected by staff relating to nursing and medical care, as well as other measurements. These were reviewed on a systematic basis and feedback was provided to staff. However, it was not clear whether this information was always benchmarked against other local or national providers.

Leadership of service

- Nursing staff within the department described a positive environment to work in. They said that they felt well supported and that senior staff were visible.
- Medical staff described their leadership as poor. We noted that the member of staff who was responsible for monitoring the performance of the department had recently stood down from this role; the lead at Northwick Park Hospital was now covering both sites.

Culture within the service

- All staff that we spoke with expressed concerns about the future of the hospital, as well as the continued functioning of the department with reduced services available on site.

Public and staff engagement

- Whilst the trust received the results of their Friends and Family Test, showing that people could make complaints or comments, no further efforts were made to engage with members of the public.
- Whilst staff had raised concerns to senior directors, it was noted that the lack of a clinical lead could be contributing to the delays in changes taking place.

Innovation, improvement and sustainability

- It was noted that pressure on staff workloads may mean that there was limited time for them to reflect on practice or undertake research.

Services for children and young people

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

Information about the service

Central Middlesex Hospital paediatric service is made up of a day surgery provision and an outpatients facility. The day surgery service operates Monday to Friday. This is managed by the critical care matron. We talked to three patients and six relatives, and eight staff, including consultants, doctors, nurses and healthcare assistants. We observed care, and we reviewed other documentation, including performance information provided by the trust. We received comments from our listening event, and from people who contacted us to tell us about their experiences.

The outpatients unit is known as the Rainbow Children's Centre and is managed by staff at Northwick Park Hospital. The Rainbow unit offers children's outpatient services three and a half days a week, and has specialist diabetes and epilepsy services. There is a dedicated paediatric haemoglobinopathy service for children and young people with sickle cell disease.

Summary of findings

The day surgery unit and the Rainbow Children's Centre at this site were differently managed. The day surgery unit was managed by staff at Central Middlesex hospital whilst the rainbow Children's Centre was staffed by staff from Northwick Park Hospital. We found huge variances between the two services and have listed them separately. The day surgery unit offered good information for families and children before procedures, had good processes and protocols, and families were pleased with the service.

By contrast, the outpatient clinics run at the Rainbow Children's Centre gave us cause for concern because there was no registered children's nurse and there were some poor practices around medicines management. The clinics were not child-friendly and lacked play facilities.

Services for children and young people

Are services for children and young people safe?

Requires improvement

The day surgery unit environment was clean and well maintained, with good standards of hygiene and clean items identified as clinically clean. Systems, processes and practices in this unit worked smoothly.

However, we had some concerns about the environment of the outpatient clinics which did not make suitable provision for children. There were no toys to occupy children while waiting for appointments, and consultation and diagnostic rooms were stark and clinical. The clinics did not have a registered children's nurse, and in the event of a medical emergency, would have to rely on the A&E department in the hospital. We observed a cluttered and untidy treatment room being used for monitoring blood pressure, which did not meet appropriate standards of hygiene and safety. We also found that levels of training varied and some were not appropriate for the service the hospital delivers.

Incidents

- Neither the day surgery unit nor the Rainbow Children's Centre had reported any serious incidents in the last two years.
- There had been no 'never events' (events that are largely preventable if the right actions are taken), in the last two years.
- Staff told us that any incidents were recorded and investigated.

Cleanliness, infection control and hygiene

Day surgery

- The environment was clean and well maintained.
- There was sufficient personal protective equipment.
- We observed staff washing their hands and using hand sanitizing gel, and all were practicing the 'bare below the elbows' policy.

Outpatients

- Hand washing facilities were adequate.
- Personal protective equipment was available.
- The waiting area and clinic rooms were clean.
- However, we did observe that there were blood splashes on the box for disposal of sharp items.

Environment and equipment

Day surgery

- This unit was well designed, clean and well equipped.
- Green labels were used and dated to denote that items had been cleaned.
- The operating theatre had specialist equipment available for paediatrics. There was a designated paediatric recovery area and equipment.

Outpatients

- Some of the clinics attended by children at Central Middlesex Hospital, such as audiology, were adult clinics and not child-friendly.
- There was no registered children's nurse associated with these clinics.
- There was no evidence of environmental risk assessments being carried out.
- The shared waiting area for ear, nose and throat (ENT) and audiology was small, and there were no toys. The play facilities had been removed after a child had tripped on a toy.
- The audiology and ENT clinics were well equipped to deliver care and treatment to children.
- One treatment room with a security keypad was propped open rather than locked, and the room was untidy. The resuscitation trolley in that room had not been checked regularly and contained a number of out-of-date items, some from 2012, and no paediatric resuscitation guidelines were available. There was an out-of-date oxygen cylinder.
- Data-scope monitors were overdue for servicing, and the lock for the room they were in did not work. There was a sign saying that the room was to be locked at all times.
- Patient trolleys used in outpatients were covered with paper, and new paper was used each day, but there was no cleaning schedule for the trolleys.
- All the above safety concerns were reported to the estates and pharmacy departments, and were rectified on the day of the inspection.

Medicines

- We had no concerns about medicines in the day surgery unit.

Services for children and young people

- However, we observed poor medicine management in the outpatients department. The drug fridge was iced up, contained an out-of-date Mantoux test vial, and was not locked. Staff stored milk in the drug fridge.

Records

- There was sufficient information recorded in children's notes, including medical history, needs for daily living, and consent, if needed, for surgical procedures.
- In the outpatients unit, we were told that notes were not always available for clinics.

Consent

- Parental consent was recorded in all the children's notes in the day surgery unit. Parents said they had sufficient information to give consent to treatment.
- Most day surgery was on younger children, but we were told that when necessary, older children were involved in discussions and gave their own consent, if assessed as competent to do so.

Safeguarding

- Staff could describe the referral process for alleged or suspected child abuse, and knew the names of the lead professionals. They were confident that the system for identifying abuse was robust and had dealt with safeguarding cases.
- The safeguarding team were based at Northwick Park Hospital. A paediatrician was the named doctor, and a nurse, the named nurse, for safeguarding.
- Only 20% of paediatric staff at the outpatient clinics had attended level 3 safeguarding training.

Mandatory training

- Only 26.8% of staff were up to date with mandatory training in the outpatient clinics.
- There was no information on how many staff had had performance appraisals in the past year.
- No disaggregated information was available on training and appraisals in the day surgery unit.

Assessing and responding to patient risk

- Children were pre-assessed before surgery, either face-to-face, or by telephone. Children with learning difficulties attending pre-assessment were assessed as soon as possible, and often in a side room, to minimise their waiting time.
- No children under two years of age had day surgery.
- Staff told us that after assessment, surgery usually occurred within eight weeks. One child we spoke with had waited only two weeks.
- Parents told us that clear and reassuring information had been given to them about surgical procedures.
- The Paediatric Early Warning System (PEWS) was used to identify children who were becoming more unwell. We saw that observations were carried out and recorded in the day surgery unit.
- The training for nurses and healthcare assistants included PEWS and the recognition of the sick child.

Nursing staffing

Day surgery

- There were sufficient staff, with the right range of skills.

Outpatients

- The outpatient clinics were run by a healthcare assistant (HCA) who worked for the rest of the week at Northwick Park Hospital. No nursing staff were employed by the clinics. The HCA told us that they would report to the children's ward manager at Northwick Park Hospital if there were any concerns.
- There was an A&E department at the hospital, and therefore emergency medical support was available if needed. However, the A&E department was due to close in autumn 2014. We noted that the withdrawal of this safety mechanism was not on the risk register.

Medical staffing

- There were sufficient medical staff for the paediatric service.

Are services for children and young people effective?

Good

The day surgery unit worked smoothly, and we were told there were relatively few cancellations. Almost all children were able to return home after their surgery. If their admission needed to be extended, they would be transferred to the ward at Northwick Park Hospital.

The outpatient clinics used national guidelines in most cases. The exception was for treating children with epilepsy.

Services for children and young people

Evidence-based care and treatment

- Evidence-based guidance from the National Institute for Health and Care Excellence (NICE) was used in most areas.
- Epilepsy management did not follow NICE guidelines, as there was no nursing support provided. Paediatricians had discussed this in a recent meeting with the North Thames Epilepsy Network.
- The trust was taking part in a regional epilepsy audit linked to Ealing Hospital.

Pain relief

- Pain relief for children undergoing surgery was given according to trust paediatric protocols.

Nutrition and hydration

- Parents of children who were coming for surgery were given information about what and when their child could drink before admission.

Patient outcomes

- Parents told us that when their child was discharged from day surgery, they were given clear information about how their child might feel after surgery, and the possible complications to be aware of.

Competent staff

- All staff on the day surgery unit and the outpatient clinics had appropriate training. We were told that mandatory training included health and safety, manual handling, infection control and basic life support. Paediatric life support training was provided regularly.
- A student nurse in the day surgery unit reported good induction on her placement.
- All staff we spoke with said that they had opportunities for career development.

Multidisciplinary working

- We saw evidence of multidisciplinary team (MDT) working in the outpatients clinics; for example, referrals to therapists were discussed in order to improve outcomes for children.
- We were told of the arrangements for young people with chronic conditions to transfer to adult services. MDT discussions started when young people were 14 or 15 depending on their maturity.

Seven-day services

- Neither the day surgery unit nor the outpatients were open at weekends.

Are services for children and young people caring?

Good

We observed good interactions between staff and children. Staff were kind and reassuring to children, and helpful in providing explanations. Parents expressed satisfaction with the nursing and medical support received.

Compassionate care

- We observed a good rapport between staff and children. Parents and children confirmed that staff were friendly and helpful.
- Families made positive comments about the care their children received.
- We saw letters and cards showing positive feedback from families about day surgery.

Patient understanding and involvement

- Parents of children attending clinics for diagnostic tests were sent written information about the tests. They reported receiving good information from staff, and trusted them to provide effective care.
- Children attending for surgery, or their parents, received information about anaesthetics and their planned procedure, as well as information about what to expect post-operatively.

Emotional support

- Parents said that they were emotionally supported by nurses and doctors who explained treatment and lessened their anxiety.

Are services for children and young people responsive?

Good

The services for children at Central Middlesex Hospital were convenient for those living in the area. The day surgery service was well used and met the needs of those it served effectively. However, the outpatient services were only used three days per week. This purpose built unit was the main area for children's outpatient services. Some speciality clinics children are seen in the adult facilities.

Services for children and young people

Service planning and delivery to meet the needs of local people

- The availability of outpatient and day surgery services at Central Middlesex Hospital was useful for those who lived in the area, as it minimised their travel time.
- The outpatient facilities were less suited to children than the similar facilities at Northwick Park Hospital. Some adult outpatients clinics were used for pediatric clinics.

Access and flow

- Day surgery had a low rate of cancellations. Surgical procedures would not be carried out on children if they had been unwell in the preceding ten days.
- The outpatient service saw between 70 and 100 children a month. Staff felt that it was underused.
- Families told us, and the clinic staff confirmed that children with outpatient appointments were seen on time.

Meeting people's individual needs

- The day surgery service was responsive to patients with complex needs and learning disabilities, and we saw that risk assessments were carried out.
- There was access to translation services, and an interpreter could be arranged if required.

Learning from complaints and concerns

- There was information displayed at the outpatient clinics about how to people could provide feedback on the service they had received, and how they could make a complaint.
- We saw information about the Patient Advice and Liaison Service (PALS) available.
- Staff told us that there were very few complaints about either the day surgery unit or outpatient clinics.

Are services for children and young people well-led?

Requires improvement

The day surgery service complemented the similar service at Northwick Park Hospital, and added capacity. It was clear how it fitted into the wider paediatric provision.

However, the Rainbow unit was not well integrated with the main paediatric services of the trust. Nor was it well supervised. The justification for providing outpatient clinics at Central Middlesex Hospital was less clear as the service was not fully utilised. The trust had not considered the risks to this service once the A&E department closes.

Some of the medical staff working at the clinic told us that they felt undervalued.

Governance, risk management and quality measurement

- Clinical governance meetings were held to discuss day surgery incidents, and training sessions were arranged to reinforce processes as necessary. For example, there had been training recently on checking labels and dosages of medicines.
- The Rainbow unit was managed by staff at Northwick Park Hospital, who were rarely on site, and appeared unaware of the quality of the provision. Managers regarded the unit as low risk.
- The medical staff in the Rainbow unit also worked at Northwick Park Hospital, and considered that senior management tended to overlook the services provided at Central Middlesex Hospital. There was no mention of these services in recent board papers.

Leadership of service

- Staff reported that the good integration of acute and community services no longer worked as well as it had in the past. The local boroughs were very different and this presented challenges.
- Staff were not aware of a board level lead for children's services.

Culture within the service

- Staff in the day surgery unit said that there was no blame attached to reporting incidents.
- Some of the medical staff at the clinics felt undervalued and mentioned tensions about the part-time working of some doctors.

Public and staff engagement

- There were no surveys of the views of children and families taken. Children's services did not use the national Friends and Family Test, and only received verbal feedback on the quality of its service.

End of life care

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

Information about the service

Palliative care is provided for all the hospitals in the North West London Hospitals NHS Trust by the specialist palliative care team (SPCT) based in the Macmillan Unit at St Mark's Hospital. Specialist palliative care is advised for patients who are suffering with advanced symptomatic disease, or who are no longer suitable candidates for curative oncological intervention. The SPCT offer support to patients who are coming to end of their life. Outpatients who require palliative care are referred to their community teams as appropriate. Patients could receive palliative care alongside active cancer treatment.

During our inspection we spoke with a number of nurses, junior doctors and consultants on several wards. We spoke with the lead consultant and lead nurse for palliative care, four specialist palliative care nurses, the lead oncology nurse, the bereavement officer, chaplain, a mortuary technician, two porters, a volunteer and two staff from the Macmillan support services. We reviewed records, policy documents, meeting minutes, audit results, the specialist palliative care patient survey and 'thank you' cards. Due to the sensitivity of the patients receiving end of life care at the time of our visit, it was not appropriate to speak to them or to their relatives and friends about the care they were receiving.

Summary of findings

We found that the end of life care to patients was good overall. The hospital had good links with the specialist palliative care team (SPCT) and community services, in order to support patients and their families. The SPCT and other services involved in end of life care were passionate, caring and maintained patients' dignity throughout their care. There was clear multidisciplinary involvement in patient care. Patients were involved in advance care planning and their preferences were observed and followed through, when possible and appropriate. People's cultural and religious needs were taken into account.

End of life care training was not mandatory within the trust, and this meant that healthcare professionals at the hospital found it difficult to attend the courses provided by the SPCT.

End of life care

Are end of life care services safe?

Good

Staff were expected to report all incidents, and they told us that they would always report incidents relating to patient safety. However, they did not always have time to report all incidents due to work pressures, or due to difficulties with the electronic reporting system.

Patient's needs were prioritised at weekly multidisciplinary meetings. The records we reviewed were found to be appropriately completed and medicines were appropriately prescribed. Staff understood how to safeguard patients from abuse, and were aware of the mental capacity act and what to do if someone was unable to give informed consent.

Incidents

- There were no 'never events' or incidents reported to the National Reporting and Learning System (NRLS) relating to end of life care.
- Staff were expected to report incidents through an electronic incident reporting system. Staff told us that they would report incidents relating to a patient's immediate safety on the electronic incident reporting system. However, they all told us that they did not always report other non-patient safety incidents, such as a delay in a patient receiving medication, through the electronic reporting system. They did say however, that they would report such incidents immediately to the most senior member of staff on duty at the time.
- Staff told us that although the electronic incident reporting system was straightforward, it did not allow them to save a report if it had not been fully completed. The SPCT worked across the whole of the hospital, which meant that they may not have all the details relating to the incident to hand (such as names of people present at the time of the incident). In such circumstances, it would rely on them going back to the ward to get the details, which was sometimes difficult after the event. Other reasons for not reporting incidents on the electronic system were a lack of time and a lack of feedback after incidents had been reported.

Safety thermometer

- The trust took part in the National Care of the Dying Audit for Hospitals (NCDAH). The audit is made up of an organisational assessment and a clinical audit. The trust achieved four out of the seven key performance indicators (KPI) in the organisation audit, and eight out of ten for the clinical audit.
- The trust did not achieve 'providing specialist support for care in the last hours or days of a person's life'. This was because they did not provide face-to-face specialist palliative care services from 9am to 5pm, seven days a week, although there is a national recommendation that this should be provided. Nationally, 21% of trusts achieved this. However, there was access to a telephone helpline out of hours.
- The clinical audit marginally fell below the national average in two areas. The trust scored 57% for multidisciplinary team (MDT) recognition that a patient was dying (nationally 59% was achieved); and 48% for medication prescribed when necessary for the five key symptoms (nationally 50% was achieved).
- The trust scored above average in all other areas of the clinical audit, which included nutrition, hydration, spiritual needs, discussions with the next of kin that the patient was dying, plan of care for the dying phase and care after death.

Medicines

- The records we looked at showed that patients whose condition could deteriorate required medicine to alleviate their symptoms. Arrangements were in place to ensure that medicines had been prescribed in advance, so that patient's waiting time and discomfort were minimised.
- The SPCT liaised with GPs and social services to ensure that people received appropriate care once they were discharged from the hospital. Patient's prescription charts showed that they had been prescribed appropriate medicines for palliative care, which included pain relief and anticipatory medicines, such as medicines for nausea and vomiting.
- The palliative care team provided patients who were returning to their home with a supply of their medicines and a leaflet listing the medicines they were taking.
- Some patients received palliative chemotherapy to support their symptoms. There was good multidisciplinary working between the chemotherapy day unit at St Mark's Hospital and the pharmacy department, to ensure that patients received their treatment without unnecessary delay.

End of life care

- Electronic prescribing was in place for colorectal and lung cancer clinics. This meant that information was easily available to all departments to ensure that drug treatments, which are time-consuming to prepare and dependent on blood test results being available, were prepared by the pharmacy on time.
- There were plans to roll out electronic prescribing to other clinics, as we were told that sharing paper-based information, such as blood test results, between departments had the potential to cause delays in the preparation of drug treatment. The unit kept supplies of supportive treatments, such as anti-emetics, to avoid having to send unwell patients to the pharmacy department, and there was good liaison between the unit and the palliative care and community nursing teams.
- Patients receiving chemotherapy on the wards were supported by staff from the day unit.
- We were told that some patients had experienced problems receiving their treatment in the community, because in some areas, community nurses required an authorisation from the GP to administer certain medicines.

Records

- Patients receiving end of life care who had been identified as 'not for resuscitation', had paperwork visible in their notes so that staff were aware of what actions to take.
- We looked at a sample of 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms across a number of wards throughout the hospital. We found that they were completed appropriately and relatives' involvement was recorded. However, the SPCT reported that not all DNACPR forms were completed correctly or completely, and they challenged staff where they found incomplete forms.
- We found that some consultants completed DNACPR records as soon as practicable after the patients arrival to the ward, while other doctors waited at least 24 hours after having the conversation with the patient and their family before completing the forms.
- The SPCT provided patients who were discharged to their home/care home/hospice with an information pack on how to support someone who was dying at home. This included information regarding a person's choice relating to being resuscitated and who had been involved in the discussions. However, we found that the information regarding discussions relating to DNACPR was confusing, as it was not clear as to whether the person wished to be resuscitated or not. This was pointed out to the team, and they planned to change the information immediately to make it clearer for people who may be reading it for the first time.
- The SPCT told us that records completed by the referring healthcare professional were often lacking in information about the patient, which meant that the clinical nurse specialist (CNS) had to make further enquiries to ascertain how quickly the patient needed to be seen.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy and procedure to identify patients who were lacking capacity to make decisions about their care. This was accessible to all staff on the organisation's intranet.
- Best interest multidisciplinary team (MDT) meetings, which involved the clinical staff and palliative care team responsible for the patient's care, took place every week.
- The next of kin/advocate was involved in decisions relating to the care for a patient who could no longer make decisions for themselves.

Safeguarding

- All staff were trained in safeguarding vulnerable adults as part of their mandatory training.
- Macmillan staff told us that they would refer someone who appeared to be at risk of harming themselves, which could be as a result of receiving bad news, to the mental health team or their GP to follow up.
- Staff could access the trust policy and procedure on safeguarding through the internal intranet system.

Mandatory training

- All healthcare professionals had completed their mandatory training.

Assessing responding to patient risk

- The SPCT told us that they would not expect to be asked to attend to every patient who was dying in the hospital, as many of the consultants at the hospital responded appropriately when a patient's condition was deteriorating.
- New patients and urgent cases referred to the SPCT were prioritised and discussed at a weekly MDT meeting.

End of life care

- The ward staff we spoke with were aware of the palliative care team and requested their support if they recognised that a patient was deteriorating or if they needed reassurance that an appropriate course of action was being taken. However, the SPCT reported that some medical staff did not agree with the advice that the clinical nurse specialist (CNS) gave and would, on occasions, continue with a course of curative treatment when a patient was in the latter stages of dying.
- The SPCT checked with nursing and medical staff as to whether a patient had responded to any changes to their treatment.

Nursing staffing

- The end of life team was mainly nurse-led. It consisted of four and a half full-time CNS, including the lead CNS, and a MDT coordinator.
- Some team members were supported and funded by Macmillan. The Macmillan team were not easily identifiable as they did not wear anything to indicate this. We were told by the SPCT that some patients were expecting Macmillan staff to support them and did not identify with the SPCT.
- The bereavement officer was a qualified nurse, and this meant they were able to answer some of the questions that the relatives of the deceased might have about the care and treatment the patient had received, as well as help them to understand the death certificate and cause of death.

Medical staffing

- There were three consultants including the lead clinician. Each consultant worked within the SPCT for one session (0.5 day) per week. The remainder of the time they worked across the hospitals in the trust. This allowed them to have a wide perspective of the patients within the hospital and areas where palliative care was required.

Extended Team

- The bereavement and mortuary services were provided by a private company, their role included transporting bodies from the wards to the mortuary.
- Oncology support and advice was available from staff running the Macmillan kiosk in the main entrance of the hospital.

Are end of life care services effective?

Good

The trust was still using some elements of the Liverpool Care Pathway (LCP) while they reviewed their procedures for the care of a dying patient as recommended by an independent review and following recommendation to phase out the LCP. The team also referred to the London Cancer Alliance for further guidelines.

We looked at a sample of patient records and saw that they received appropriate pain relief, nutrition and hydration. Staff were appropriately trained and supported, and there were regular multidisciplinary meetings.

Evidence-based care and treatment

- Following the independent review of the use of the LCP for the Dying Patient, and the subsequent announcement of the phasing out of use of the LCP, the trust had made some interim amendments, which included the removal of direct and indirect references to the LCP. An essence of the LCP was still in place, as the staff had found that the assessment tools were useful.
- The trust policy and procedure was under review, and there was a steering group reviewing the recommendations to replace the LCP.
- The team referred to the London Cancer Alliance (LCA) for further guidelines.

Pain relief

- The patients we reviewed received appropriate pain relief.

Nutrition and hydration

- The patients we reviewed received appropriate pain relief.

Patient outcomes

- The trust took part in the National Care of the Dying Audit for Hospitals (NCDAH). The trust achieved four out of the seven key performance indicators (KPI) in the organisation audit, and eight out of ten for the clinical audit.
- The SPCT had analysed the main findings of the audit and proposed a number of recommendations to improve the service provided.

End of life care

- The trust opted out of the bereavement audit summary as a majority of patients' notes did not contain the next of kin details, so they were unable to obtain bereaved relatives views.
- The SPCT had good links with the community palliative care team, so that patients could receive continued support within the community.
- The team accessed the electronic data system 'co-ordinate my care' for patient's using the system.

Competent staff

- All nursing staff had annual appraisals on their performance with their manager.
- Staff had a supervision meeting with their manager once every six months.
- The CNS and consultants were required to complete continuing professional development courses, and they attended various other courses relating to their role in end of life care.
- The team had increased their profile with the trust; however, this had led to an increased referral rate across the trust, from 450 in 2012 to 1,000 in 2013. Staff resources were stretched, as their workload had doubled and the staff numbers had remained the same.
- End of life training was offered by the SPCT to all staff within the trust. However, this was not currently mandatory as recommended nationally.
- The end of life training included communication training, how to have difficult conversations, identifying the signs of dying, and policies on syringe drivers.
- The SPCT team told us that it was difficult to engage junior doctors and consultants in the training, and nursing staff found it hard to attend due to work pressures. 25% of staff had undertaken training.
- The private company, which was responsible for the bereavement office and mortuary, arranged for people's bodies to be transported from the wards to the mortuary.
- Some of the SPCT CNS's were taking qualifications to become nurse prescribers. This meant that they would be able to prescribe appropriate medication, as well as advise on them.
- The bereavement office assisted junior doctors on how to fill out the medical certificate of death in order to prevent the registry office rejecting them for being completed incorrectly. This meant that distress to families would be minimised.

Multidisciplinary working

- Multidisciplinary palliative care meetings were held weekly. New and complex cases were discussed. We were told that the chaplaincy team were invited to these meetings, but rarely attended. The chaplaincy told us that they were unaware that they were invited to attend the meetings.
- The extended multidisciplinary team members were invited to attend the end of life team's annual operational meeting, so that they could to agree to its operational policy.

Seven-day services

- The SPCT was available at the hospital from 9am to 5pm from Monday to Saturday.
- Out-of-hours support services were provided by Michael Sobell Hospice at Mount Vernon Hospital.

Are end of life care services caring?

Good

During our inspection we did not speak with any patients or their families/friends about the end of life care services, as it was a sensitive time for people, and it was felt that it was not appropriate to intrude on their circumstances. We observed staff treating people with compassion, dignity and respect. Other staff were able to explain how they cared for and supported people.

Records showed patients and their families were involved in discussions relating to their care. A named ward nurse was allocated to patients for continuity of care. There were other support services available, such as a multi-faith chaplaincy and Macmillan cancer care services.

Compassionate care

- During our inspection we saw patients being treated with compassion, dignity and respect. 'Thank you' letters showed how much patients and their families valued the support, advice and care that the SPCT gave to them.
- Staff spoke passionately about how they cared and supported people.
- Normal visiting times were waived for relatives of patients who were at the end of their life.

End of life care

- The SPCT told us they encouraged ward staff to sit with patients who did not have regular visitors at the end of their life.
- If appropriate, a patient was moved to a side room to offer more privacy when they were nearing the end of their life. If this was not possible, curtains were drawn around their beds.
- Deceased patients were moved from the ward to the mortuary as soon as was practicable.

Patient understanding and involvement

- Patients were given a named nurse on the wards.
- The clinical nurse specialists (CNS's) were not allocated to individual patients, as they were required to support a number of patients over all the hospitals. The team tried to ensure that no more than two CNS supported one patient in order to maintain continuity in their care.
- Patient records that we viewed showed that conversations regarding end of life care, which had taken place between healthcare professionals, patients and their families, were recorded.

Emotional support

- CNS supported patients and their relatives. People were given as much time as they needed to talk about their thoughts and feelings.
- Macmillan staff were available at the hospital, and provided support to friends and relatives.
- Patients had assessments for anxiety and depression, and appropriate clinical support was offered.
- Multi-faith chaplaincy was available to provide spiritual support.
- The bereavement officer supported relatives/friends after the patient's death by explaining all the legal processes, and what to expect after someone has died. They provided an information pack which included the contact details for support and counselling groups.

Are end of life care services responsive?

Good

Overall, we found the end of life care service to be responsive to people's needs. It had been identified by the SPCT and the NCDAH that some staff did not recognise the stages of dying, which meant that some patients may continue to receive curative medicines which might not be appropriate. However, the number of patients referred by healthcare professionals to the SPCT had doubled in the last year, which meant that more staff were recognising the signs of a deteriorating patient.

Most wards/departments did not have an adequate room where sensitive conversations could be held with families. However, patients coming to the end of their life were moved into side rooms if appropriate, in order to allow privacy.

Service planning and delivery to meet the needs of local people

- The SPCT knew how many patients they were supporting with end of life care. However, we were not able to identify how many patients in the entire hospital were receiving end of life care with support from the ward staff and their consultant.
- The SPCT profile had increased over the last year and their workload had doubled, as more staff referred patients to them. However, the team size had remained the same. The staff reported that this meant they were often completing reports in their own time at the end of their shift to allow them enough time to spend with patients and their families.

Access and flow

- Patients whose condition was identified as deteriorating could be referred to the SPCT by any healthcare professional in the trust. The community palliative care team could refer patients to be admitted to the hospital.
- Based on figures from the period September 2012 to the end of February 2013, on average half of the patients referred to the SPCT were referred by doctors, the remaining half were referred by ward staff and specialist nurses.
- Hospital staff had access to an electronic co-ordination system to refer patients to the SPCT.
- 60% of patients were receiving palliative care for cancer-related illness; 40% were non-cancer related.
- Patients were seen by a CNS within 24 hours of referral for urgent cases, and within three days for non-urgent cases. We saw that all referred patients had been seen within the relevant time scales.
- Patients who had a terminal illness were supported in being discharged to a place of their choice. This could be achieved within 24 hours if all the relevant assessments and community resources were readily accessible. The CNS administered the discharge for

anyone under their care. This was a lengthy process and could take them up to five or six hours. This meant they were taken away from spending time with other patients. The CNS we spoke with told us that they would value administrative support to assist them with discharges and allow them more time with patients.

Meeting people's individual needs

- The SPCT had identified that some healthcare professionals did not always recognise the early stages of dying and therefore, on occasions, continued with curative treatment when it was not appropriate.
- Interpreters were available for people who were unable to understand English.
- A multi-faith chaplaincy was available. There were full-time Church of England and Catholic priests, and part-time Muslim, Jewish and Hindu spiritual leaders available.
- We were shown a breakdown of where people wished to die against the number who actually died in their preferred place. However, this had not been fully completed since February 2013. The six months prior to that showed that a majority of people did not die in their preferred place. We were unable to ascertain the reason for this.

Learning from complaints and concerns

- Complaints were monitored by the lead CNS. Any learning and patterns were identified and discussed at the team meetings. The SPCT had received three complaints in the last year, and they had all been investigated appropriately by the complaints department.
- The chaplaincy ran a multi-faith user group, where they discussed patient care. One concern raised related to staff not being aware of religious days or festivals for different faiths. As a result of this, a multi-faith calendar was produced and placed in multiple locations within the hospital. This meant that staff could support patients with their faith. We noted that the calendar did not indicate what was required on the given day, such as wearing particular clothing or fasting times, so staff were not made aware of what the event meant to the individuals to whom it related.

Facilities for relatives

- There was a prayer room, a quiet room, and a chapel. There were bathroom facilities which included a foot bath.

Are end of life care services well-led?

Good

We found that overall, the end of life care services were well-led. The trust had recently appointed a non-executive director to lead on end of life care. It was too early to say if this would raise the profile of the service at board level and increase the focus on providing good end of life care for every patient within the trust.

We found strong positive leadership across all the services involved in end of life care. All staff were passionate about their work in supporting and caring for patients and their families. Patients, their families and staff were asked for their views of the service. The SPCT were undertaking a number of research programmes to find ways to reduce the number of unnecessary hospital visits for patients nearing the end of their life.

Vision and strategy for this service

- The end of life team had an annual general meeting, where they discussed and agreed their operational policy, and work plans and priorities for the following year. This included the Macmillan, bereavement and chaplaincy services.

Governance, risk management and quality measurement

- Palliative care and oncology clinical governance meetings took place every three months.
- MDT team meetings took place every week. Complaints, concerns or issues were raised, discussed and planned for.
- The clinical lead told us that the MDT relationship was not as robust as it could be, and they were in the process of establishing a more integrated model of working to include the hospital discharge teams and community services

Leadership of service

- Many of the staff we spoke with said that they would not know the executive board members and had not seen them on the wards engaging with staff and patients.
- The trust had recently appointed a non-executive director to lead in end of life care. The lead clinician and

End of life care

CNS spoke positively of this appointment, and felt that the future would be positive. However, it was too early to say whether this would increase the profile of end of life care within the trust.

- The lead clinician and lead CNS were responsible for the day-to-day running of the team. They were very energetic and had a positive vision for end of life care within the trust.
- All the CNS felt supported by the management team, and shared in the department's vision to provide a caring and responsive approach for people requiring palliative care.
- The management team and staff all agreed on the challenges and pressures they faced.
- The privately-run bereavement office and mortuary reported a good working relationship with the hospital.

Culture within the service

- Most of the staff we spoke with were unsure of the future of the hospital and what it would mean for their role. They all felt that any progression had been put on hold due to the merger plans.
- Staff we spoke with in relation to end of life care spoke positively and passionately about the work they did in supporting patients approaching the end of their life, and supporting the family and friends during and after the patient's death.
- The SPCT and Macmillan support services worked closely together, and supported each other in ways to improve the patient's experience. This was paralleled by the bereavement office, mortuary and chaplaincy.
- Most of the staff we spoke with on the wards were aware of the SPCT. However, many of them were not aware of the training that the team offered.
- Staff reported that it was difficult to be released from the wards to participate in extra training as work pressures often prevented them from attending voluntary courses.
- Staff told us that it was difficult to engage junior doctors and consultants in end of life care training.

Public and staff engagement

- Relatives/friends of people who died at one of the trust's hospitals were invited to complete a survey. Between March and October 2013, 100 surveys were given out. 16 completed surveys were received. Staff told us that the return rate was probably low because they related to a very sensitive subject, which people may not want to think about.
- The department used learning outcomes from the NCDAH audit to improve their services.
- Staff told us that they would engage with people at the time if there were any concerns.
- We saw there were a number of 'thank you' letters from relatives outlining areas of care they appreciated, such as support and comfort.
- The CNS within the SPCT felt involved and supported in putting forward any ideas they had to improve the service they offered.
- Staff who attended courses run by the SPCT were asked their opinion of the training. A majority indicated that the courses helped them considerably in recognising a dying patient and how they could support them.

Innovation, improvement and sustainability

- The SPCT implemented a study in improving the outcomes for patients by establishing an integrated heart failure (HF) pathway. The aim of the project was to develop an integrated approach to the assessment and care of patients with advanced HF, to ensure better identification, palliation of needs and choices at the end of life. The results improved cardiac and palliative care for patients, improved the use of hospice and community services, and reduced the number of inappropriate admissions to hospital. It gained huge endorsement from community HF nurses.
- As a result of the success of this study, the SPCT secured two Darzi fellows to lead a service development programme to reduce the number of admissions to hospital for patients with long-term conditions, or who were frail in the last years of their life.

Outpatients

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

Information about the service

Central Middlesex Hospital is one of three locations run by the North West London Hospitals NHS Trust, which last year provided a service to 374,000 outpatients.

The outpatient clinics are located throughout the hospital. Each clinic is held in a designated location which is termed a 'pod'. These have their own waiting areas. Individual clinics are run in these areas with their own reception desks. Some areas run two clinics, and the administrative staff are also located within the individual clinics. Clinics are organised and run by a co-ordinator, with some co-ordinators being responsible for more than one clinic. There is a senior coordinator who has overall supervisory responsibility and reports to the general manager of outpatients, who is based primarily at Northwick Park Hospital.

During our inspection we visited the clinics for rheumatology, dermatology, diabetes, orthopaedics and urology. We met with 10 staff including receptionists, nursing staff, healthcare assistants, consultants, administration staff and clinic coordinators. We spoke with six patients. We looked at the patient environment, and observed waiting areas and clinics in operation.

Summary of findings

Patients received compassionate care and were treated with dignity and respect by staff. The environment was clean, comfortable, well maintained and safe. Staff were professional and polite, and promoted a caring ethos.

Clinicians took sufficient time in consultations, and patients said that they felt involved in their care. Clinics started on time and generally ran to schedule. The rheumatology clinics were regularly oversubscribed and had long waiting times, but action was being taken to recruit an additional consultant.

Outpatients

Are outpatients services safe?

Good

The patient outpatient areas were clean and well maintained. Infection control procedures were followed and regular audits were completed. Patient records for the individual clinics were kept securely. Medication was securely stored, and regularly checked and audited.

Patients we spoke with told us that they thought the outpatients department was a safe place to visit for treatment.

Incidents

- There had been no 'never events' or serious incidents reported in the outpatients department.

Cleanliness, infection control and hygiene

- We visited the waiting areas for all of the clinics and also saw six of the consulting rooms. All were clean and well maintained. Patients said that the consulting rooms were always clean. One patient told us "yes this place is always clean, I cannot fault it".
- An external contractor provided the cleaning service and was also responsible for building maintenance. Staff told us that if additional cleaning was required, the request was responded to promptly. We were also told that when maintenance was required which impacted on health and safety, action was taken quickly.
- Daily infection control audits were completed by the nursing staff, and monthly audits by the infection control lead for the hospital.
- The toilet facilities were regularly checked and cleaned.
- 'Bare below the elbow' policies were adhered to in the clinical areas.
- Hand hygiene gel dispensers were provided in the access areas to all the various clinics, with reminders about their usage for patients and staff. We observed these being used by patients and staff.
- Staff completed infection control training as part of their core mandatory training.

Environment and equipment

- Outpatient clinics were located throughout the three floors of the main hospital building. We visited all of the clinic areas, and they all were comfortable and well maintained. The manager explained that the outpatient clinics had been purpose-built. The building provided a safe environment for patients. Clinics were well signposted and easily accessible to patients.
- Resuscitation equipment was located on each floor. All equipment was checked daily by the nursing staff and checks were recorded. The equipment was also checked regularly by the hospital's resuscitation team.
- Equipment used in the clinical areas was correctly serviced and maintained. Records reviewed confirmed this. Equipment that had been serviced was labelled and dated. Audits were completed on the servicing of equipment.

Medicines

- Medicines were stored correctly in locked cupboards or fridges where required. The cupboards were checked daily by the nursing staff, and inspections were also carried out by the pharmacy department. We spoke with one nurse, who described how they checked the medication storage and recorded this information.
- Patients we spoke with told us that they received appropriate information about the medication they were prescribed, and that changes to their medication were explained to them.
- Written information about medication was only available in English. This could mean that for some patients there could be difficulties in understanding the directions.

Records

- Patient records were held in the reception area for each clinic. Records could be moved between clinics using a trolley. We saw on one occasion that some records were left unattended momentarily. However, the staff member had turned the notes over to protect people's confidentiality.
- Temporary notes were in place at some of the clinics. An explanation was supplied with the notes as to why the full set of notes was not in place. This was often due to a patient having been seen at another hospital within the previous 24 hours and there not being sufficient time to transport the notes.
- Information about patients was also available electronically.

Outpatients

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients gave their consented appropriately and correctly. Patients we spoke with told us that the clinical staff asked for their consent before commencing any examination or procedure.

Safeguarding

- All nursing and other healthcare staff we spoke with confirmed that they had completed safeguarding training, and were aware of the procedure to follow should they need to report a concern.
- Information about safeguarding was displayed in several parts of the outpatients area.
- Patients we spoke with told us that they thought the outpatients department was a safe place to visit for treatment.

Mandatory training

- All staff were required to complete a range of mandatory training, which included fire safety, safeguarding, moving and handling, and infection control. Staff told us that they had completed this training and also any required updates. Staff were aware of their responsibility to ensure that they were up to date.
- The co-ordinator of each clinic checked mandatory training as part of the staff's annual appraisal process.

Staffing

- Each clinic had its own reception area which accommodated the support staff for that clinic. There were enough staff to ensure that patients were attended to within a reasonable timescale. The clinics we visited all had their designated staffing levels in place.

Major incident awareness and training

- In case of a failing of the electronic booking system, each clinic had a paper record of the day's appointments.
- All staff completed training in fire safety, and nominated staff were designated fire wardens with allocated responsibilities in the event of a fire.

Are outpatients services effective?

Not sufficient evidence to rate

We report on effectiveness for outpatients below. However, we are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients.

Evidence-based care and treatment

- We were told that guidelines, such as NICE guidelines, were followed where appropriate.
- Staff were aware of how to access policies and procedures online. Nursing staff told us how new practice guidance was cascaded, either through the department, or through the specialist area they were working in.

Patient outcomes

- Patients we spoke with were positive about the outpatients clinic service. One person told us "they are great and the doctor is amazing". Another person said "they always listen to me and when my medication changed the doctor explained all the reasons and the side effects I might look out for, she was really excellent".
- We were told by two co-ordinators and a consultant that the outpatients department was helped by having many of the doctors who ran clinics based at the Central Middlesex Hospital site. We were told that this helped with continuity of care, and promoted good communication between the clinic staff and the medical staff.

Competent staff

- Staff we spoke with told us they had annual appraisals on their performance, and this was monitored by the pod co-ordinators. When appraisals were due, any mandatory training that a staff member needed to complete was also brought to the attention of their manager.
- We spoke with two consultants, and they told us that they were supported by a professional team of staff. We were told that the teams were well organised and skilled in their various roles.

Seven-day services

- The outpatient service provided a Monday to Friday service.

Outpatients

Are outpatients services caring?

Good

We found that the outpatient services at Central Middlesex Hospital were focused on patients and committed to providing a positive experience of treatment. We observed staff interacting with patients in a caring and respectful manner. All the patients we spoke with told us that the staff were caring and polite.

Compassionate care

- All the patients we spoke with were very positive about the approach of the staff. We were told that staff treated people with respect, and were polite and caring. One patient told us "the doctor does regular monitoring and reviewing of my medication and explains things carefully".
- People we spoke with told us that they felt listened to and were given time to ask questions.
- Patients' confidentially was respected. Patients and staff told us that there were always rooms available to speak to people privately and confidentially.
- Two patients commented that the staff were "very committed and knowledgeable" and one said "I feel like I am not just a number when I come here, they take their time".

Patient understanding and involvement

- Patients we spoke with told us that they were involved in their care. They told us that the nursing staff and consultants explained things clearly and always answered any questions.

Emotional support

- Staff told us they would be aware when a patient may have received difficult or distressing news, and would offer to talk to them privately after their consultation. Staff would also ensure that patients were aware of any appropriate support services they might wish to use. One patient we spoke with told us, "it has been a difficult time but the doctor and staff have been absolutely brilliant".

Are outpatients services responsive?

Good

Clinics generally ran on time, and action was being taken to address the high demand for rheumatology and orthopaedic clinics. The flexibility of the role of the clinics care co-ordinators helped the service respond quickly when additional support was needed.

Service planning and delivery to meet the needs of local people

- Data supplied showed that the trust provided an average of 500 clinics a month for between 27,000 and 33,000 patients.
- Extra clinics could be arranged in conjunction with the specialist departments, to accommodate more patients.

Access and flow

- At Central Middlesex Hospital staff and patients told us that the clinics usually ran on time and that patients did not have to wait long for their consultations. The main exception to this was the rheumatology clinic, which struggled to meet the demand for appointments. We were also told that there could be delays in the orthopaedic clinics. Action was being taken to improve waiting times. We were told that recruitment was being organised for additional consultants for both of these clinics.
- There was a degree of flexibility when patients booked appointments, though this depended on the clinic concerned.
- A trial had been run using texting to remind patients of appointments, but the trust had decided not to implement this as a permanent service.

Meeting people's individual needs

- Patients could be provided with transport following an assessment of their eligibility. Information about this service was displayed in the waiting areas. Staff told us that they would also check with patients to see whether they wished to apply for this service.
- Staff said they would liaise with carers and relatives when someone with complex needs had an appointment, to ensure that they had the correct support to attend their appointment. One healthcare assistant explained how they had contacted a care home to ensure that an elderly patient visiting later that day had their transport correctly arranged.

Outpatients

- In the older people care clinic, patients were telephoned the day before their appointment as a reminder, and also to ensure that they had their transport arranged. Also, patients who failed to arrive for oncology appointments were contacted by the clinic staff, and if they were able to travel to the hospital that day, the consultant would see them.
- There were systems in place for staff to use an interpreting service. It could be arranged for an interpreter to be present or accessed via a phone link.

Learning from complaints and concerns

- Data from the trust showed there had been no formal complaints made about the outpatients department in the previous 12 months.
- The co-ordinators told us that they attempted to resolve concerns informally by talking to patients. We were told that the only issues they had dealt with in the previous 12 months were concerning appointments running late or being cancelled. Information about making complaints was displayed in the outpatients area. Senior staff we spoke with were aware of the trust's complaints policy and the procedure to be followed. Information was also displayed regarding the Patients Advice and Liaison Service (PALS).

Are outpatients services well-led?

Good

There was a strong caring ethos within the outpatients department, and staff were patient-focused. Staff were clear about the management structure and the lines of accountability. Managers and senior staff were approachable and staff felt listened to.

Leadership of service

- Staff we spoke with were positive about the management and leadership provided in the outpatients department. They said that they worked as a team, and were confident about approaching the senior staff about concerns or to ask for advice.
- We were told that senior staff were approachable and supportive.
- Each pod area held monthly meetings for all the staff. The co-ordinators also held monthly meetings with the medical staff. We saw the minutes from staff meetings, which showed that information was being cascaded down to staff, and also general issues were being raised and discussed. For example, one area of discussion had been a reminder to staff to be aware when some clinics may be short staffed at short notice, and extra support could be offered. The pod co-ordinators also met every two weeks as group.

Culture within the service

- All the staff we spoke with were positive about the model of outpatients that was being operated. Two of the co-ordinators we spoke with said that they were proud of the service that was being delivered, and believed that the department was positively focused on meeting patient needs. One healthcare care assistant we spoke with told us "I think this is a great environment to work in, I really love it".

Public and staff engagement

- Staff were aware of the distribution of trust information via a briefing called 'Team Talk' on the intranet, and also of the hospital magazine which was produced quarterly.
- Several staff had also attended the staff open forums which had been held in the hospital with members of the trust board. These meetings were held on average every three months.
- Senior staff we spoke with said they were kept informed about trust developments and felt that they were an important part of the organisation.

Innovation, improvement and sustainability

- The outpatients department had developed a new role titled 'clinical care co-ordinator'. These staff combined administration skills with healthcare assistant skills, which enabled them to move between the two roles. This provided greater flexibility for covering staff absence, as people could be asked to move temporarily at short notice to support another clinic if required. Staff who had taken on this new role told us that it gave them greater job satisfaction. They also said that they believed it helped the department provide a better service to patients. The manager told us that this development was key to the flexibility that was needed to run the department smoothly.

Outstanding practice and areas for improvement

Outstanding practice

- The STARRS service had strong ownership by geriatricians and the multi-disciplinary team. The team was aware of the needs of frail elderly patients who attend A&E. It was introduced by the trust and its partners to mitigate one of the pressures on the A&E service and the hospital's beds.

Areas for improvement

Action the hospital SHOULD take to improve

- Review the lack of a paediatric nurse in the children's outpatient department.
- Ensure that critical care services are audited in line with others, so that benchmarking can take place to drive improvement.
- Review the end of life care provision at this hospital, so that patients receive intervention at an appropriate stage.
- Ensure that departments where children are treated are child-friendly.
- Review epilepsy services for children to ensure that current guidance is in place.