North Middlesex University Hospital NHS Trust

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

This was the second comprehensive inspection of The North Middlesex University Hospital NHS Trust under the Care Quality Commission (CQC) methodology for inspecting hospitals.

We carried out an announced inspection between 20 and 23 September 2016. We also undertook unannounced visits during the following two weeks.

We inspected eight core services: Urgent and Emergency Care, Medicine (including older people's care, Surgery, Critical Care, Maternity and Gynaecology, End of life Care, Services for Children and Outpatients and diagnostic services.

We have rated the hospital trust as Requires Improvement overall.

Our key findings were as follows:

Safe

- There was improved clinical governance and leadership of Urgent and Emergency care and oversight of the ED at a trust level.
- There was an increase in consultant and middle grade doctors in the ED and an increase in night time medical cover, since our last inspection.
- We found full utilisation of the Royal College of Paediatrics and Child Health (RCPCH) Situation awareness for everyone (SAFE) programme and the use of the MIDSEY huddles optimised patient safety and the early detection of deteriorating patients.
- Actions from a previous never event in surgery actions had not been fully implemented.
- There was an inconsistent approach to the sharing of learning from incidents.
- Safeguarding training level 2 adults and children was below target level for both nurses and doctors.
- None of the nursing staff working on the surgical assessment unit completed advanced life support training.

Effective

- Patients were offered pain relief in a timely manner.
- Patients had access to an immediately available, fully staffed emergency theatre and a consultant on site at any time of the day or night.
- Unplanned readmission rates for critical care within 48 hours of discharge were better than the national average.
- The unplanned re-attendance rate to ED within seven days was consistently worse than the national average.
- Multi-disciplinary work between the ED and other specialisms was not yet fully embedded
- The hospital did not comply with the national guidance which recommends that the ratio of recovery beds to operating theatres should not be less than two.
- There was no out of hours cover for the Specialist Palliative Care Team (SPCT). This was not compliant with NICE guidelines.
- Unplanned readmission rates for critical care within 48 hours of discharge were better than the national average.

Caring

- In most areas of the trust we observed staff treating patients and their relatives with compassion and kindness.
- Staff demonstrated a good understanding of the importance of privacy and dignity and maintained this for patients and their relatives.
- Bereavement officers were very caring and helpful towards bereaved families and went the extra mile to assist with making appointments for the relatives with the authorities to register the death of a loved one.
- In maternity services we observed that privacy and dignity were not always protected and staff did not always address patients in the appropriate manner.
- The results for the NMUH CQCs Maternity Survey of Women's Experience of Maternity Services 2015 were worse than other trusts for all indicators for the labour and birth and staff during labour, and birth section of the report. Results were about the same as other trusts for care in hospital after birth.
- Once the initial holistic assessment had taken place by the Specialist Palliative Care Team, there was no counselling support offered to patients. If they required this service, they had to request referral and wait to be accepted and seen by the psychologist.

Responsive

Summary of findings

- The rate of cancelled operations from April 2014 to March 2016 was consistently lower than the England average. If cancelations occurred patients were treated within the subsequent 28 days.
- Changes implemented to the surgical assessment unit and introduction of the 'hospital at home' team helped to manage the flow within the hospital and ensure patients were treated in an optimal environment.
- There were effective systems to ensure patients' individual needs were identified and met by staff. This included an electronic 'flagging' system to identify patients with additional support needs and personalised '10 things about me' assessments.
- The trust was meeting national waiting times for diagnostic imaging within six weeks and outpatient appointments within 18 weeks for incomplete pathways.
- The ED was not meeting the target time to admit, transfer or discharge 95% of patients within 4 hours of their arrival in the ED.
- The ED was not meeting the ambulance handover target time of 15 minutes, however performance against this was being actively monitored.
- Staff did not have specialist knowledge of the needs of patients who lived with dementia or patients with a learning disability. There was no children's learning disabilities nurse and patients were not identified or flagged on admission.
- Patients told us it was often very difficult to get through on the appointments telephone helpline to either change an appointment or seek advice.

Well Led

- Staff felt positive about the changes in the trust's senior management team and said communication and organisational culture was improving.
- A new management team had been introduced to the ED since our last inspection. Staff reported that they felt supported in their roles by the new departmental management team. There was clear nursing and medical leadership visibility with the department and staff felt able to highlight issues to them.
- Staff expressed some uncertainty about the implications for them in relation to the newly developed relationship with another trust.
- Clinical service risk registers did not fully indicate how risks were mitigated and who was responsible for implementing actions.
- In maternity several members of staff described a culture of bullying and discrimination.
- There was no clear End of Life Care (EoLC) strategy. At the time of our inspection there was no identified non-executive director appointed for oversight of EoLC within the trust despite this having been brought to their attention during our last inspection in 2014. We have since been informed that a non-executive director had filled this position in June 2016.

We saw several areas of outstanding practice including:

- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- Outpatient and diagnostic services had strong leadership. Staff were inspired to provide an excellent service with the patient at the centre.
- The diagnostic imaging department worked hard to reduce the patient radiation doses and had presented this work at national and international conferences.

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

Importantly, the trust must:

- The trust must code their complaints correctly to reflect palliative and end of life care complaints.
- The trust must send out bereavement surveys to the relatives of patients who have died within the hospital.
- The trust must produce and ratify an end of life care strategy.

Importantly, the trust should:

- Ensure learning from incidents is more robust and shared with all staff.
- Ensure that all medicines and instruments associated with a resuscitation are disposed of safely afterwards.
- Ensure the renewal of advanced paediatric life support (APLS) certificates of those doctors and consultants whose certificates had expired
- Improve mandatory training levels for medical and nursing staff.

Summary of findings

- Improve safeguarding adults level 2 training for medical and nursing staff.
- Improve safeguarding children level 2 training for medical and nursing staff.
- Improve hand hygiene levels to ensure consistency especially amongst medical staff.
- Ensure medical and nursing staff are fully trained and able to identify and support the needs of patients living with dementia.
- Ensure medical and nursing staff are fully trained and able to identify and support the needs of patients with learning disabilities.
- Improve appraisal rates of nurses.
- Ensure all actions in response to the never event are fully implemented.
- To analyse causes for higher than the national average mortality rate as suggested by the bowel cancer and the national hip fracture audit data.
- Carry out an audit of the stillbirth rate for the period Jan – Dec 2016 and develop an action plan to address themes.
- Provide one to one care in labour to all women.
- Replace all damaged equipment in Emergency Gyanecology Unit and triage.
- Monitor and report VTE compliance
- Monitor the temperature of medicines storage
- Carry out a review of culture within maternity and use tools such as 'walk in my shoes'.
- Review waiting times in triage and develop an action plan to address themes.
- Ensure mandatory training and multidisciplinary intrapartum care training targets are met.
- Display cleaning schedules or checklists all clinical areas.
- Ensure all staff observe the 'bare below the elbows' policy.
- Ensure patients have a named midwife.
- Ensure there are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up.
- Ensure there are appropriate processes and monitoring arrangements in place to improve the 32 and 61 day cancer targets in line with national targets.
- Ensure there is improved access for beds to clinical areas in diagnostic imaging.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to North Middlesex University Hospital NHS Trust

The North Middlesex University Hospital NHS Trust is a medium-sized acute trust with around 515 beds, serving approximately 590,000 people living in Enfield and Haringey and the surrounding areas including Barnet and Waltham Forest. In the 2015 Indices of Multiple Deprivation, both Enfield and Haringey were ranked in the most deprived quintile.

The trust had an annual revenue of around £250 million, and reported a deficit of £8 million at the time of the inspection. The trust employs 2,458 staff. The trust provides a full range of adult, older people's and children's services across medical and surgical disciplines.

In 2015/16 the trust reported activity figures of 56,880 inpatient admissions, 348, 276 outpatient attendances and 171,840 admissions through the Accident and Emergency department.

We inspected all eight core acute services including: Urgent and Emergency Care, Medicine (including older people's care, Surgery, Critical Care, Maternity and Gynaecology, Services for children, End of life and Outpatients and diagnostic services.

Our inspection team

Our inspection team was led by

Chair: Dr Tim Ho, Medical Director, Frimley Health NHS Foundation Trust

Team Leader: Nicola Wise Head of Hospital Inspection Care Quality Commission

The trust was visited by a team of CQC inspectors, assistant inspectors, analysts and a variety of clinical and non-clinical specialists. There were consultants in emergency medicine, medical care, surgery, paediatrics, cardiology and palliative care medicine and junior doctors. The team also included midwives as well as nurses with backgrounds in surgery, medicine, paediatrics, neonatal, critical care, palliative care and board-level experience, and a team of experts by experience.

How we carried out this inspection

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

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

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

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

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These organisations included the clinical commissioning

Summary of findings

groups, Monitor, Health Education England, General Medical Council, Nursing and Midwifery Council, Royal College of Nursing, NHS Litigation Authority and the local Healthwatch.

We observed how patients were being cared for, spoke with patients, carers and/or family members and reviewed patients' personal care or treatment records. We held focus groups with a range of staff in the hospitals and community services, including doctors, nurses, allied health professionals, administration, senior managers, and other staff. We also interviewed senior members of staff at the trust.

What people who use the trust's services say

Friends and Family Test

In the Friends and Family Test the percentage of patients who said they would recommend the trust was consistently equal to or slightly lower than the England average, during the time-period, June 2015 to May 2016.

Patient led assessments of the care environment (PLACE)

The trust was below the England average in the measures of food, cleanliness, privacy, dignity and well-being, but was higher than the England average for facilities in 2015.

Summary of findings

Clinical Commissioning Groups (CCGs)

Haringey and Enfield CCGs provided feedback ahead of our inspection. It was highlighted that in the prior eighteen months there had been a broad range of quality challenges at North Middlesex University Hospital which required escalation to NHS England, NHS Improvement and other regulators.

Summary of findings

In January 2016 commissioners triggered the National Quality Board Risk Summit guidance due to concerns about the protection of quality and safety. In addition to this, two risk summits have been triggered by the General Medical Council due to concerns about the quality of education and supervision of medical trainees.

The A&E department was one of six priority areas requiring trust focus due to the deterioration in the performance of the national 4 hour wait target and the emergence of significant workforce challenges. The need to secure additional senior doctors within the A&E department and concerns about quality of the training environment for junior doctors was identified and has remained a key priority for the trust and the local NHS system.

Following an A&E Risk Summit held on 8 February 2016, outcomes included the production of a Trust plan setting out the immediate actions required to improve safety and the creation of a 'quality and safety dashboard'. From the beginning of March 2016 commissioners, NHSE and NHSI held weekly teleconferences to oversee delivery of the immediate actions required to protect patient safety and to hold the Trust to account for performance against the A&E dashboard.

During the three months, prior to this inspection, there have been significant changes to the Trust executive team. Commissioners acknowledge the efforts being made to improve governance to support the delivery of safe treatment including actions taken by the medical director to address gaps/weaknesses in systems relating to patient safety and risk. The incoming Director of Nursing is being open with commissioners about the work required to strengthen governance processes and responsive when issues are escalated.

Summary of findings

Health Watch Haringey and Enfield

Healthwatch Haringey and Healthwatch Enfield provided feedback prior to our inspection. Healthwatch Enfield reported that of the 64 issues and comments raised between August 2015 and August 2016, 35 of these related to complaints, twenty related to comments, whilst 9 related to compliments. The most common issues and themes related to: hospital inpatient stays, hospital outpatient appointments, A&E and phlebotomy services.

Facts and data about this trust

The North Middlesex University Hospital NHS Trust is medium-sized acute trust with around 515 beds, serving approximately 590,000 people living in Enfield and Haringey and the surrounding areas. It employs around 2,498 staff that deliver care to the Haringey and and Enfield population. The trust delivers acute and elective services.

Key Figures

Beds: 515, of which 487 beds for general and acute use, 55 beds for maternity and 23 beds for critical care

Staff as of 1st April 2016: 2,457.9 WTE (whole time equivalent), against a budgeted establishment of 2,657.9 WTE. Of these:

431.4 WTE were medical staff, against a budgeted establishment of 491.8

979.9 WTE were nursing and midwifery staff, against a budgeted establishment of 1,066.8 WTE

1,046.6 WTE other staff, against a budgeted establishment of 1,099.3 WTE

Financial data 2015/16

Revenue: £250 million

Full Cost: £258 million

Deficit: £8 million

Activity type 2015/16

There were 56,880 recorded inpatient admissions

There were 348,276 recorded outpatient attendances

There were 171,840 recorded attendances through the Emergency Department

Summary of findings

Safe?

The number of NRLS incidents reported per 100 admissions was similar to the England average.

There were no cases of trust-assigned methicillin-resistant Staphylococcus aureus (MRSA) reported between June 2015 and May 2016.

There were 40 cases of Clostridium difficile (C. diff) reported over the same period. Prevalence of C. diff was higher than the England average in all but three months.

There were five cases of Meticillin Sensitive Staphylococcus Aureus (MSSA) reported over the same period. Prevalence was lower than the England average throughout this period.

Rates of pressure ulcers, falls with harm and urinary tract infections (UTI's) in patients with a catheter reported to the Patient Safety Thermometer showed no clear trends

The proportion of consultants was lower than the England average and the proportion of junior doctors was higher than the England average.

There were 61 serious incidents were reported between July 2015 and June 2016, including one never event. Treatment delays were the most common type of serious incident reported. This was followed by sub-optimal care of the deteriorating patient incidents, diagnostic incidents and maternity incidents. The never event was a medication incident.

Effective?

There were two active mortality outlier alerts as of 27 July 2016. These were for therapeutic operations on the jejunum and ileum and senility and organic mental disorders. Three mortality alerts were received in June 2015 but these have since been closed following local review.

Summary of findings

Caring?

In the Friends and Family Test the percentage of patients who said they would recommend the trust was consistently equal to or slightly lower than the England average.

The number of written complaints received by the trust was lower in 2015/16 than in 2014/15. However the number of complaints received increased each year between 2012/13 and 2014/15.

In the Cancer Patient Experience Survey 2015, the trust scored "lower than expected" for 30 of the 50 indicators. These included all the indicators relating to diagnostic tests, "finding out what was wrong with you" more generally and home care and support. They also included all but one of the questions relating to 'deciding on the best course of treatment'. There were no indicators where the trust performed better than expected.

The trust performed worse than the England average for three of the four areas in the Patient Led Assessments of the Care Environment 2015. Facilities was the only area where the trust performed better than the England average.

The trust performed worse than the England average for five out of 12 selected questions from the CQC Inpatient Survey 2015. These included availability of hand-wash gels, staff providing enough help to patients with eating their meals and emotional support from staff.

Responsive?

The two most common reasons for delayed transfers of care between May 2015 and April 2016 were "Awaiting further NHS non-acute care" (31.5%) and patient or family choice (21.9%). These were both much more prevalent for the trust than for England as a whole.

Bed occupancy was consistently above the England average from quarter 3 of 2014/15 to quarter 4 of 2015/16.

Summary of findings

Well Led?

The sickness absence rate was consistently below the England average between February 2015 and January 2016.

In the 2015 GMC National Training Scheme Survey the trust performed worse than expected for five areas: clinical supervision, induction, supportive environment, access to educational resources and feedback. It performed within expectations for the remaining nine survey areas.

The trust's response rate of 28% in the 2015 NHS Staff Survey was lower than the England average of 41%. The trust had two positive findings: quality of non-mandatory training, learning and development; and staff motivation at work. There were 12 negative findings. These included: the percentages of staff experiencing bullying, harassment or abuse from the public and other staff in the last 12 months, the percentage of staff recommending the trust as a place to work or receive treatment and the percentage of staff experiencing discrimination at work in the last 12 months. The trust was within expectations for the remaining 20 questions.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? The trust is rated as requires improvement for safety. We found examples of safe care in some of the services we inspected, however rated End of Life Care, Medical Care, Urgent and Emergency Care, Surgery, Critical Care, Maternity and Gynaecology, Outpatients and Diagnostics were rated as requires improvement. We found: • In surgery actions in response to the never event were not fully implemented. • There was an inconsistent approach to the sharing of learning from incidents. • Some staff were not aware of the requirement of recording pressure ulcers as incidents on the hospital's electronic incidents reporting system. • Concerns were identified by NHS England specialised commissioning body about the use of root cause analysis methodology and the variable quality of investigation reports. • There was high usage of agency doctors and nurses across the trust. • Safeguarding training level 2 adults and children was below target level for both nurse and doctors. • None of the nursing staff working on surgical assessment unit completed advanced life support training. • There were inconsistencies in staff understanding of major incidents. • The paediatric service had a lack of ownership or oversight of children being cared for in services outside of the paediatric department. • The number of paediatric staff without advanced paediatric life support (APLS) and paediatric immediate life support (PILS) training put children at risk in the event of an emergency requiring timely resuscitation. However; • There was improved clinical governance and leadership of Urgent and Emergency care and oversight of the ED at a trust level. • There was an increase in consultant and middle grade doctors in the ED and an increase in night time medical cover, since our last inspection.	**Requires improvement** 

Summary of findings

- We found full utilisation of the Royal College of Paediatrics and Child Health (RCPCH) Situation awareness for everyone (SAFE) programme and the use of the MIDSEY huddles optimised patient safety and the early detection of deteriorating patients.

Cleanliness, infection control and hygiene

- Many of the areas that we visited were visibly clean and tidy. However we found that some areas of outpatients and diagnostics had instances of floors and sinks which were not clean.
- Hand washing facilities and alcohol gel were readily available on the wards.
- During our inspection of the post mortem suite we found there was a crossover of the dirty utility and the clean utility.
- Within gynaecology services national specifications for infection prevention and control and cleanliness were not adhered to. These included: requirements for hand washing facilities in Health Building Notice (HBN) 00-09: Infection control in the built environment, and the requirements for cleaning, cleaning schedules, and checklists set out in the Health and Social Care Act 2008: code of practice for health and adult social care on the prevention and control of infections and associated guidance. There were no handwashing sinks in the EGU. There was also no clean utility or treatment room or a dirty utility area in EGU. Staff had to use the facilities in the adjoining ward (S2) or in EPAU. This meant an increased risk of cross contamination.

Duty of Candour

- The Duty of Candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The trust had promoted DoC, most staff were aware of the requirements, however knowledge was mixed, with some senior medical staff not able to describe the requirements. The majority of staff, however gave examples of the DoC, including apologising and sharing the details and findings of any investigation.
- The trust induction programme included training in DoC. In addition, training was provided to all consultants, matrons and

ward managers on an annual basis and was also included as part of the Trust's two day root cause analysis (RCA) investigation training programme, and was part of the junior doctor induction programme for trainees.

- Senior staff told us they were confident that DoC was addressed in an open and transparent way, they encouraged staff to see it as a collective responsibility and discussed DoC during Incidents meetings.

Safeguarding

- In line with statutory guidance the trust had named nurses, named doctors and safeguarding teams for child protection and safeguarding vulnerable adults. The hospital had policies for safeguarding children and vulnerable adults, which included guidance on female genital mutilation (FGM).
- We saw that gang-related violence and female genital mutilation (FGM) projects had been well managed and that staff spoke with were fully aware of these safeguarding issues.
- Staff were required to complete level 1 and 2 safeguarding training for adults and children and the trust set a target of 90% for staff compliance with the requirement. Performance against this standard was variable across the different Divisions.
- Staff we spoke with had a good understanding of safeguarding concerns for adults and children.
- The electronic patient recording system enabled staff to flag up vulnerable children and adults. They could document whether the child was known to social services, whether there was a child protection plan in place and whether there were other family issues, such as an aggressive parent.

Incidents

- The trust used an electronic incident reporting system. Staff were aware of the incident reporting procedures and how to raise concerns. Staff told us they were encouraged to report all matters of concern, including when a shift was short staffed. Across the trust we heard accounts of staff being too busy to record incidents.
- Staff were unclear about how learning from incidents was shared and did not think that there was systematic dissemination of learning from incidents across different departments. Senior staff corroborated that hospital-wide learning was not yet systematic. We found evidence of risk newsletters within some clinical Divisions, however not all staff

were aware of these. We found the organisation was not resourced to track incidents trends, across the different clinical areas, however work had been progressed to promote incident reporting.

- Concerns were identified by NHS England specialised commissioning body about the use of root cause analysis methodology and the variable quality of investigation reports.
- We found that not all nursing staff were aware of the requirement of recording pressure ulcers as incidents on hospitals electronic incidents reporting system. This meant there was no record which would allow staff to analyse trends, prompt investigation, and ensure trust policies related to incidents were followed in order to prevent future occurrence.
- Within critical care, we found Health Care Assistants (HCA's) did not have access to the incident reporting system, despite working clinically with patients. HCA's told us they would approach a senior member of staff to submit an incident report if needed. However, there was a lack of evidence HCAs had a robust knowledge of recent incidents or outcomes.
- Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Following a never event in February 2016 involving wrong route administration of medication staff told us safety huddles were introduced in response. An action plan in response to the incident mentioned that red tabards with 'do not disturb' sign on it were to be introduced to indicate nurses were dealing with medication and minimise disturbance. However, we did not see them in use in all areas. The action plan stated bank and agency staff were required to confirm that they achieved competency in giving IV medications. However, staff told us that this requirement was not implemented as they did not have to show proof of Intravenous fluid administration (IV) training prior to administering IV medication.
- In Paediatrics we found the clinical teams used the SAFE programme. North Middlesex Hospital had been one of 28 hospitals which had worked with the RCPCH in participating in a two year programme to develop and trial a suite of quality improvement techniques to improve communication, build a safety-based culture and deliver better outcomes for children and young people, known as SAFE. The SAFE programme was designed to reduce preventable deaths and error occurring in the UK's paediatric departments.

Summary of findings

Assessing and responding to patient risk

- National Early Warning System (NEWS) was used across the hospital to assist staff in the early recognition and escalation of a deteriorating patient.
- Situation-Background-Assessment-Recommendation (SBAR) framework was used to support staff in escalating concerns in a clear and concise manner.
- The World Health Organisation (WHO) surgical checklist was in use in operating theatres. We observed that three of the five steps of the WHO checklist was completed (sing in, time out, sign out) and the procedure appeared embedded in staff practice, however this was not routinely monitored or audited.
- None of the nursing staff working within the unit completed advanced life support training. The Resuscitation Council recommends that all staff working in acute areas completes advanced life support training to ensure they are able to recognise and treat the deteriorating patient using a structured approach and manage a cardiac arrest.

Staffing

- The trust had vacancies across all staff groups, vacancies were mitigated with the use of bank, agency and locum staff.
- The organisation used an acuity tool every few months to monitor safe staffing levels. The trust did not use a daily acuity tool to measure staffing levels against the mixture of patient needs within the clinical areas, however the roll-out of a commonly used tool was underway.
- Staff would use their clinical judgement and if additional staff was needed, the nurse in charge would complete a form that would be authorised by the local matron and the head of nursing.
- Since our last unannounced inspection, we found a local induction process had been introduced within the Emergency Department (ED) for nurses and we saw that it included a description of the role of the agency worker and an introduction to the department, alongside key policies.
- Within critical care we found an increase in nursing and HCA vacancies between April 2016 and June 2016. This resulted in critical care being understaffed by an average of 12 WTE nurses

and HCA's per month. Agency nurses were employed to address the short fall in permanent staff. The senior Executive were aware of the staffing issues and were exploring supportive measures.

- Within critical care we found that orientation checklists for temporary staff were were inconsistent and did not demonstrate corrective action where a lack of knowledge was indicated by the agency nurse.
- Within maternity and gynaecology services, we found that there was a deficiency in staffing of midwives, as measured against the Birthrate Plus® workforce planning tool, which demonstrates required versus actual staffing need. The birth to midwife ratio was 1:32, this less than the national average of 1:28. This had been recognised by the managerial team and a business case for a further 12 WTE midwives had been approved prior to our inspection, however posts were not recruited to.
- As a result of the last CQC inspection, various bodies, including two local clinical commissioning groups (CCG) and NHS England specialised commissioning body combined to monitor the trust's performance and activity and the delivery of quality services. Their combined report confirmed they had received assurance from the trust that there were a sufficient number of middle grade doctors within the ED. This would be reviewed on a monthly basis by a clinical led review group.
- The consultant establishment in ED was increased to 14 whole time equivalent (WTE) from 12 at our last inspection. We found that a the increase in medical staffing had been supported on a short-term secondment basis, however we did not find clear sustainably plans for business as usual activity, for when these staff return to their host organisation.
- The trust was not meeting the minimum requirement set out by the Royal College of Physicians which states that there should be 1 WTE palliative care consultant per 250 beds, with the trust employing a total of 1WTE consultant against a bed-base of 515 beds.

Major incident awareness and training

- The trust had a major incident policy and staff told us it was included in their induction training.
- We inspected the major incident room which contained major incident equipment and up to date action cards. We found this room to be well organised and action cards up to date.

Summary of findings

- There was a decontamination room, where people would be taken for example, in the event of a chemical incident. When we asked to view it, it took a member of staff 40 minutes to find the key. The facilities in the decontamination room were poor.
- We saw that gang-related violence and female genital mutilation (FGM) projects had been well managed and that staff spoke with were fully aware of these safeguarding issues.

Are services at this trust effective?

Requires improvement

Overall we rated the effectiveness of the trust as requires improvement. We saw examples of effective care in services such as surgery, critical care Maternity and Gynaecology, and services for Children and Young People. We rated all other areas as requires improvement. This was because:

- The unplanned re-attendance rate to ED within seven days was consistently worse than the national average.
- Multi-disciplinary work between the ED and other specialisms was not embedded
- The hospital did not comply with the national guidance which recommends that the ratio of recovery beds to operating theatres should not be less than two.
- Bowel cancer patients' related data suggested the risk-adjusted two-year post-operative mortality rate was much higher than the national average.
- There was no out of hours cover for the Specialist Palliative Care Team (SPCT). The SPCT only provided a palliative and end of life care service Monday to Friday between 9am and 5pm. This was not compliant NICE guidelines.
- We found DNACPR documents had been completed without patient involvement due to lack of capacity. We noted, against trust policy, mental capacity assessments were not always completed.

However;

- The hospital performed better than the England averages for two of the three knee-replacement indicators.
- Patients had access to an immediately available, fully staffed emergency theatre and a consultant on site at any time of the day or night
- Unplanned readmission rates for critical care within 48 hours of discharge were better than the national average.

Evidence based care and treatment

Summary of findings

- The trust's policies and treatment protocols were based on organisational guidelines from professional organisations such as the National Institute for Health and Care Excellence (NICE) and the Royal Colleges. Staff were able to access guidelines on the intranet.
- Within the ED we saw some of the available policies included fracture of neck of femur, neutropenic sepsis, asthma, management of adult paracetamol overdose, anaphylaxis and stroke CVA and TIA. However, the clinical director told us that there was a need to develop more pathways, including chest pain and frailty pathway.
- The ED had just begun to audit sepsis screening, and timely administration of medicines and fluids in September which meant that there was no available data at the time of our inspection.
- The trust did not complete regular audits to prevent surgical site infections during pre-operative period, and post-surgery to check if patients' body temperature and glucose levels in diabetic patients were adequately maintained. The audit would allow ensuring adherence with the National Patient Safety Agency and the Department of Health guidance.
- The National Institute for Clinical Excellence recommends that all patients should be assessed for risk of developing thrombosis (blood clots; VTE assessment) on a regular basis. We observed that the hospital did not fully comply with this recommendation.
- The hospital did not comply with the national guidance issued by the Association of Anaesthetists of Great Britain and Ireland, related to recovery room facility. This guidance recommends that the ratio of beds to operating theatres should not be less than two. There were ten recovery bays for eight operating theatres.
- An audit in critical care highlighted low levels of knowledge and understanding amongst staff of sepsis diagnosis and treatment. This audit led to study days being offered but no follow-up had been conducted to ensure they had been effective.
- The trust failed to meet the set key performance indicators (KPIs) for the '5 priorities of care for the dying patient'. They performed below the national England average.

Patient outcomes

- The unplanned re-attendance rate to ED within seven days was consistently worse than both the 5% standard, but was lower than the England average of 7.73%.

Summary of findings

- In the RCEM audit of asthma in children 2013/14, the ED failed to meet any of the standards. It performed in the lower England quartile for four standards. It performed between the upper and lower England quartiles for the remaining six standards.
- The hip fracture audit indicated all patients admitted with hip fracture in 2015 were assessed for bone protection medication (England average 96.5%). The hospital improved its results when comparing with the previous year (91%). The same audit suggested that the 18.2 days mean length of total trust stay was longer than the England average of 15.7 days.
- The number of patients past surgical resection, who were ill and needed to remain as an inpatient for longer than five days, was higher at the hospital (91%) than the national average (69%) according to the national bowel cancer audit (2014). Risk-adjusted 90-day post-operative mortality rate (4.6%) was slightly worse than the national average (4.4%). Similarly risk-adjusted 90-day unplanned readmission rate at 19.6% was in line with the expectations (19.2%). However data suggested the risk-adjusted 2-year post-operative mortality rate (36.1%) was much higher than the national average (22.7%).
- The critical care unit reported a mortality rate of 22%, which was slightly worse than the national average of 18%. However, unplanned readmission rates within 48 hours of discharge were better than the national average.
- In maternity services the normal delivery rate, homebirth and baby born before admission (BBA) rates were not recorded on the dashboard. We saw documentary evidence for April to August 2016 that demonstrated the normal delivery rate was 55% (1156), which is less than the RCOG recommendation of 60%
- The trust carried out an audit between March 2015 and April 2015 of 102 patients who had died whilst at the hospital. This audit showed the trust were able to identify just over half of the amount of patients approaching the end of their life, however the per centage of patients with documentation of their individual needs and preferences was very low. The trust recognised patients were not receiving a complete and thorough end of life care assessment and identified steps requiring improvement.
- The trust was not in-line with NICE guidelines for palliative care which state there should be seven day, face to face palliative care provision Monday to Sunday, between 9am and 5pm with an out of hours service provided.

Multidisciplinary working

- We saw examples of multidisciplinary team (MDT) working embedded across the trust. In many services, we found evidence of good multidisciplinary relationships supporting patients' health and wellbeing. We observed multidisciplinary input in caring for and interacting with patients on the wards.
- Within the ED nurses we spoke with told us that there was still weakness in internal multidisciplinary team working (MDT) as identified in the last report. We were told that there was, on occasion, poor and late clinical decision making, dependent on the consultant in charge.
- We were told that there had been an improvement in MDT working between the ED and other departments within the hospital, though there were still some areas of weakness.
- We were told by staff that joint working between interventional radiology and cardiology had been problematic. The issues had been escalated and a local agreement reached but some senior staff felt the solutions were unsustainable.

Competent staff

- Following the reconfiguration of the progressive care unit (PCU) as a high dependency unit (HDU) and the subsequent merger with the intensive care unit (ICU), the trust had funded 23 nursing staff to undertake a post registration qualification in critical care nursing. As a result 43% of nurses had completed this award. This did not meet the 50% minimum recommended by the Royal College of Nursing (RCN) but the unit was due to achieve a 51% completion rate by April 2017. All shift coordinators and practice educators had achieved this award, which met the requirements of the RCN and the ICS core standards for intensive care medicine.
- Within the ED there was an increase in appraisal rates for nurses since the last inspection, when completion rates were between 37% and 50%. Recent figures were still below the 90% target rate and ranged between 56% - 63% in June to 75% - 79% in August.
- There was a significant deterioration in appraisal rates for medical staff from 100% between January and May to 40% for June and July. There were no figures available for August.
- The NMC Midwives Rules and Standards (2012) require a ratio of one SoM for 15 midwives. We saw that the SoM ratio was 1:19 (London LSA Report 2015) which means that there were not enough SoMs to support midwifery practice, identify shortfalls

and investigate instances of poor practice. However, following the inspection we saw in the new published report (London LSA Report 2016) that the SoM ration was 1:12 which shows there was enough SoMs to support midwifery practice.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- The majority of nursing and medical staff we spoke with demonstrated a good understanding of mental capacity and knew about the importance of assessments of people with mental health needs or learning disability.
- Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguard (DoLS) training was included in the mandatory e-training program as part of safeguarding level 1 training for medical and nursing staff. It is also included in the level 2 face-to-face safeguarding adult training.
- Senior staff were aware of the DoLS principles and told us they completed DoLS applications for patients requiring 1:1 care but there were no patients under a DoLS during our inspection. Knowledge of DolS amongst junior staff was inconsistent.
- Staff were not clear of their duties and responsibilities in relation to patients who lacked mental capacity.
- The trust carried out a sample consent form audit in April 2016 to check compliance with the trust consent policy and improve safer practice of consent within the hospital. It was noted that overall the trust made some improvement in standard of recording the information on consent forms.
- Do Not Attempt Cardiopulmonary Resuscitation (DNACPRs) orders were not fully completed. Of the eighteen DNACPR that we reviewed, seven indicated that the patient lacked capacity. Five of these did not have evidence of a mental capacity assessment.

Are services at this trust caring?

Requires improvement

Overall we rated caring at the trust as requires improvement. We saw many examples of caring care within most services, however we rated medical care, maternity and gynaecology and end of life care services as requires improvement. We rated caring as Requires Improvement overall because:

- In maternity services we observed that privacy and dignity were not always protected.
- In maternity services we found that staff did not always address patients in the appropriate manner.

Summary of findings

- The results for the NMUH CQCs Maternity Survey of Women's Experience of Maternity Services 2015 were worse than other trusts for all indicators for the labour and birth and staff during labour, and birth section of the report. Results were about the same as other trusts for care in hospital after birth.
- The bereaved relatives survey had not been sent out to families since 2013, despite being available. The trust was unable, therefore, to get clear feedback on the standard of care provided and were unable to benchmark against other providers.
- Once the initial holistic assessment had taken place by the SPCT, there was no counselling support offered to patients. If they required this service, they had to request referral and wait to be accepted and seen by the psychologist.

However:

- In most areas of the trust we observed staff treating patients and their relatives with compassion and kindness.
- Staff demonstrated a good understanding of the importance of privacy and dignity maintained this for patients and their relatives.
- In maternity services women were able to telephone Maternity Direct in working hours and triage out of hours for emotional support.
- Patients said they found the SPCT caring although they did not have much time they could spend talking to each of them.
- Bereavement officers were very caring and helpful towards bereaved families and went the extra mile to assist making appointments for the relatives with the authorities to register the death of a loved one.

Compassionate care

- We observed interactions between staff and patients and saw staff treated patients with compassions and kindness. Staff engaged in an open and positive way with patients and their relatives.
- The Trust acknowledged that it struggled with ED Friends and Family Test (FFT) response rates, particularly for A&E. Reasons given for this included disruptions with the text messaging service (which has now been rectified) and ongoing difficulties with theft of response collecting equipment.
- In gynaecology services we observed privacy and dignity was not always maintained. In the Emergency Gynaecology Unit (EGU) patients were cared for in recliner chairs in a shared

lounge with an open door from a corridor which was a point of access to a general surgical ward and the Emergency Paediatric Assessment Unit (EPMU). There were no screens between each chair area or on the windows between the seating area and the corridor which we saw meant that visual and auditory privacy were not always achieved. The chairs were in close proximity to each other as well as the communication station used by staff.

- In maternity services we found there was no provision for privacy for patients arriving in triage to discuss reason for attendance. Furthermore, we observed clinical care carried out in the waiting room.
- For end of life care services the hospital had created a bereaved relatives survey approximately a year prior to our inspection, however they had not sent these out. We were told the survey had not been sent out as the trust were working with other hospitals delivering end of life care on this project, and needed to have their approval. This meant the service was unable to assess the care delivered, or benchmark against other care providers.

Understanding and involvement of patients and those close to them

- We found variable evidence of clinical staff involving patients, and their relatives, in their care, dependent on the services we visited. This ranged from patients in the ED who described feeling involved in their care, to some relatives in critical care who did not feel that they had been provided with enough information.
- Within surgery we found patients undergoing hip or knee joint replacements were invited to attend the 'bone school' before their surgery. This allowed them to find out how they could prepare for their operation and what to expect when in the hospital and once they were discharged.
- A local audit in 2016 demonstrated the trust needed to improve advanced care planning for patients approaching the end of life.

Emotional support

- We found the trust provided a wide and diverse chaplaincy team which reflected the diverse needs of the local population. It included Jewish, Christian, and Muslim chaplains. There was an on-site chapel, a multi-faith room and a Muslim prayer room.

Summary of findings

- Relatives were provided with guidance on practical steps following a bereavement. It contained information on how to access the Chaplaincy, an explanation in the event of a post mortem and how to register the death.
- We found information leaflets available for patients and relatives available on wards.
- Cancer patients had also access to a cancer support centre run by a local charity and located in the radiotherapy and oncology waiting area. It helped patients emotionally and physically by providing complementary therapy services such as massage and counselling.
- The hospital worked in partnership with a charity which provided advocacy service offering statutory and informal advocacy services. This was to support people who had mental health needs, learning disabilities and sensory and communication impairments among others.
- There was limited counselling support available for patients approaching end of life. Most patients that spoke with us during the inspection had not received any counselling and had not been offered this service.
- The chaplaincy was available to staff as well as patients. They were involved with debriefings in complex or particularly difficult cases, or if there had been a traumatic incident. They were able to offer emotional and spiritual support for all those involved, however they did not receive clinical supervision themselves.

Are services at this trust responsive?

Requires improvement

Overall we rated responsiveness of services at this trust as requires improvement. We found evidence of responsive care in surgery and critical care. However, we rated the remaining core services as requires improvement.

During our inspection we found:

- The ED was not meeting the target time to admit, transfer or discharge 95% of patients within 4 hours of their arrival in the ED.
- The ED was not meeting the ambulance handover target time of 15 minutes, however this was being actively monitored.
- There were issues around flow, from the ED to the wider hospital, when patients require admitting resulting in patients waiting in the ED for a number of hours until a bed became available on a ward.

- Staff did not have specialist knowledge of the needs of patients who lived with dementia or patients with a learning disability.
- There was poor oversight in paediatrics of patients living with learning disabilities. There was no children's learning disabilities nurse and patients were not identified or flagged on admission.
- The trust did not routinely collect data to indicate if all qualifying patients were screened for dementia.
- Patient information leaflets were not provided in a variety of languages
- Patients told us it was often very difficult to get through on the appointments telephone helpline to either change an appointment or seek advice.
- The SPCT were not aware of all palliative or end of life care patients within the hospital.

However;

- The trust had provided two separate rooms on the observation ward which were designated for less ill mental health patients.
- The trust had employed youth workers within the ED to address gang warfare and health care issues caused by violence in the borough.
- The rate of cancelled operations from April 2014 to March 2016 was consistently lower than the England average. If cancellations occurred patients were treated within the subsequent 28 days.
- Changes implemented to surgical assessment unit and introduction of the 'hospital at home' team helped to manage the flow within the hospital and ensure patients were treated in an optimal environment.
- There were effective systems to ensure patients' individual needs were identified and met by staff. This included an electronic 'flagging' system to identify patients with additional support needs and personalised '10 things about me' assessment.
- The trust was meeting national waiting times for diagnostic imaging within six weeks and outpatient appointments within 18 weeks for the incomplete pathways.
- There was access to interpreters for patients whose first language might not be English and the outpatient department employed three Turkish link workers to meet the needs of the local population.

Service planning and delivery to meet the needs of local people

Summary of findings

- We found the hospital catered for a culturally diverse population in which many different languages were spoken. There were telephone and face-to-face interpreting service available.
- There was a secure room for mental health patients which met the standards set out by the Psychiatric Liaison Accreditation Network.
- Senior staff told us in order to improve patient experience and safety, two rooms on the observation ward were designated for less ill mental health patients and adapted to be ligature safe.
- There was a designated surgical assessment unit to assess patients who visited the emergency department and had a confirmed or probable surgical condition.
- The hospital had a fully staffed theatre available 24 hours a day to allow staff to perform immediate life, limb or organ-saving interventions within minutes of when decision to operate was made. This allowed staff to act in acute emergency without interrupting an elective list and to prevent cancellation of that list and re-booking the patients.
- In critical care guidance and information for carers was available on the unit, including a carers passport scheme. The carers passport scheme had been due for review in July 2015, however and there were no documented updates to the scheme more recently than this.

Meeting people's individual needs

- Patients with a learning disability had a hospital passport, which included information about them. This included things staff must know about the patient, things which were important and the patient's likes and dislikes.
- There were designated champions for people with a learning disability in some areas, however we found implementation of this was inconsistent across the trust, with some services informing us that they did not have learning disability champions in place.
- We noted that one local authority had a Learning Disability Partnership and had introduced a 'purple folder' which included the patient's health action plan (HAP). Any treatment issued to the patient should be recorded in the purple folder. We found staff had an awareness of this but it was not widely in use.

- In critical care we found there were limited resources on the unit to help staff communicate with patients with a learning disability.
- We found evidence that patients' individual needs were highlighted by nurses during pre-assessment to allow adequate planning and preparation prior to a surgical admission.
- We found paediatrics had employed youth workers in the ED and this had been positively received and helped address gang violence.
- We found that advanced care planning was an area the trust felt it needed to improve. Palliative care patients were encouraged to plan their future wishes in advance, such as their treatment options and where they preferred to be cared for and eventually die. The SPCT provided training to staff to help initiate this conversation with the patient and their loved ones in good time, to enable the patient the opportunity to make their own decisions with as much information and support as possible
- The hospital provided a chapel and muslim prayer room. We were informed of a multi faith room for other denominations. The chapel had many icons and pictures that were in keeping with the Roman Catholic religion. There was a notice on the door that described the chapel as an 'inclusive Christian place of Worship' rather than a multi faith area.
- In an adjoining area based just outside the main building was the multifaith area which included a muslim prayer room. The muslim prayer room contained many prayer books, a very small separate area for women and a male and female washing area. The washing area did not look clean or cared for.
- There were no separate area for other denominations including Hindus, Sikhs or Jewish people.

Dementia

- The trust developed a dementia strategy action plan at the beginning of 2016. Amongst the actions identified was that the senior clinical lead for dementia should ensure that a named healthcare professional acted as a point of contact for people with dementia and their families during the admission to hospital. The update on the information submitted to CQC stated that there were dementia champions in place. However, staff we spoke with were not clear whether there was a designated champion for people living with a dementia in their departments.

- Other actions from the plan was that 100% of staff should have basic dementia awareness training and updates. There was no definitive data to corroborate this at the time of our inspection.
- We found evidence of adjustments being made for patients living with dementia for example being placed first on the operation list.
- We found evidence of a flagging system within the patients' electronic record system to indicate special needs or if any adjustments to care and treatment was required.
- Some staff we spoke with said, whilst they tried very hard to engage with a person living with dementia, they did not always feel confident they had the skills to do this to the best of their ability.
- Staff completed the '10 things about me' with patients and their relatives to enable them to better understand their patients and hence meet their specific needs. We saw completed '10 things about me' forms in some records we reviewed.
- Nurses and doctors told us patients aged 75 and above admitted as inpatients were routinely screened for dementia within 72 hours of admission. However, the trust did not collect detailed up to date data to indicate all qualifying patients were screened.

Access and flow

- During our last inspection the trust was unable to tell us how they captured the 15 minutes to triage. Recent data submitted to us for this inspection demonstrated that this was being routinely captured.
- As a result of the last CQC inspection in April, various bodies, including two local clinical commissioning groups (CCG), local authorities and NHS England specialised commissioning body combined to monitor the trust's performance and activity and the delivery of quality services.This monitoring body reported to CQC that there had been a steady improvement in the Trust's performance against the 4 hour wait target since the last CQC inspection. This was attributed to factors which included the new leadership in ED, additional senior medical support secured by NHS England, and the Trust's Safer Faster Better transformation programme.
- Our last inspection identified that the department consistently breached the four hour ED waiting time, with targets as low as 65% between August 2015 and May 2016. Data submitted to

Summary of findings

CQC indicated that whilst the 95% target was attained only once in the 21 weeks between May and September, the average performance for June was 77%, July 90%, August 92% and 87% for three weeks in September.

- We found that ward matrons were involved in bed management alongside the clinical site management team, the meeting was led by the managing director and each of the divisions were represented. It allowed ensuring patients' needs were prioritised and appropriate treatment and interventions commenced without delays.
- Surgical wards were supported by the 'hospital at home' service which provided 17 'virtual beds' which were shared across specialities. The team was responsible for arranging care packages and support at home. The team liaised between primary care and community services to try to prevent readmission to hospital. Staff said the transition from hospital to home worked more effectively after the service was introduced.
- Cancelled operations were lower as a percentage of elective admissions than the equivalent England figure for August 2014 to March 2016. There was a downward trend in cancelled operations expressed as a percentage of elective admissions, which showed that the hospital was cancelling fewer procedures and was performing better than the national average.
- The utilisation rate for operating theatres between March 2016 and May 2016 was low and varied between 62% and 81%. We did not observe it to have any impact on patients care; the hospital was working towards achieving 87% to improve efficiency.
- In critical care between April 2015 and March 2016, 14% of patients experienced a discharge to a ward between 10pm and 7am. This is described as an 'out of hours discharge' and can lead to additional clinical complications for patients. This rate was significantly higher than the England average of 4%.
- Discharge delays from critical care were significantly lower than the national average. Between April 2015 and March 2016, 77% of patients were discharged within four hours of the decision being made compared to a national average of 36%.

- Staff and patients reported long waiting times in antenatal clinic. We were told that women often sit on the floor in clinic because there are not enough chairs to cater for the size of the clinic, for example up to 140 women could attend the clinic on a Wednesday.
- The referral to treatment rate for incomplete pathways between July 2015 and June 2016 ranged from 91.4% and 99.4%. The results have been consistently above been the standard of 95% since July 2015.
- The percentage of cancer patients seen by specialist within two weeks of an urgent GP referral was below the 93% standard in quarters 2 and 4 of 2015/16 and quarter 1 2016/17. The standard was met in quarter 2 of 2016/17.
- The percentage of cancer patients waiting less than 62 days from urgent GP referral to first definitive treatment was below the 85% wait standard and England average in quarter 2 of 2015/16 and quarter 1 2016/17. Despite the standard being met in quarter 3 and quarter 4 of 2015/16 the standard was at 73.8% in quarter 2 of this year.
- Waiting times for diagnostic imaging were monitored and recorded. The percentage of patients receiving their diagnostic test within 6 weeks from referral was at 99% in May 2016.

Learning from complaints and concerns

- Patients we spoke to knew how to raise concerns. Patient information leaflets explaining service user rights, the trust's complaints process and the Patient Advice & Liaison Service (PALs) were available in wards, clinics and patient areas.
- The Patient Advice Liaison Service (PALS) was available Monday to Friday 9am until 5pm. They had an office based within the hospital building where patients and relatives could visit, if they had a concern or a complaint about the hospital or the treatment they received. They also provided a telephone number and an answerphone service for out of hours messages, as well as an email address for contacting the service.
- The trust took on average 26.4 working days to respond to formal written complaints
- The trust had an internal complaint response deadline target of 85% for acknowledging formal complaints within 48 hours for complaints received.

Summary of findings

- In the ED staff told us that there had been an improvement in the sharing of complaints which were more frequently fed back at handovers, since our last inspection.

Are services at this trust well-led?

Requires improvement

The trust is rated overall as requires improvement for well led.

We recognise that at the time of our inspection a new trust leadership team had recently commenced in post with a new Chief Executive Officer (CEO), Medical Director (MD), Chief Nurse (CN) and an interim Chief Operating Officer (COO). Staff told us members of the senior executive team were visible and approachable.

We rated leadership as requires improvement because:

- Staff expressed some uncertainty about the implications for them in relation to the newly developed relationship with another trust.
- There appeared to be very limited resources for planning and undertaking a program of clinical audit based on trust wide key patient safety policy areas such as falls and pressure ulcers.
- Clinical service risk registers did not fully indicate how risks were mitigated and who was responsible for implementing actions.
- Staff described a culture of bullying and harrassment in both critical care and maternity services.
- There was no clear EoLC strategy. The hospital were aware of improvements they needed to make, however they did not have a clear action plan to achieve this. EoLC only had one risk on their register despite the other concerns that they had identified during the inspection.
- At the time of our inspection there was no identified non-executive director appointed for oversight of EoLC within the trust, despite this having been brought to their attention during our last inspection in 2014. We have since been informed that a non-executive director had filled this position in June 2016.

However:

- Staff felt positive about the changes in the trust's senior management team and said communication and organisational culture was improving.

Summary of findings

- A new management team had been introduced to the ED, since our last inspection, staff reported that they felt supported in their roles by the new departmental management team. There was clear nursing and medical leadership visibility with the department, and staff felt able to highlight issues to them.
- The hospital worked to develop innovative pathways were surgical patients could avoid admission and prolong hospital stay by involving the 'hospital at home' team and surgical assessment unit in their care.

Leadership of the trust

- At the time of inspection, the senior leadership team comprised of a longstanding, substantive Chair, John Carrier, in post since June 2013. The trust had a newly appointed CEO, Libby McManus appointed in July 2016. A new Medical Director in post February 2016, a new Director of Nursing and Midwifery in post August 2016, and an Interim COO. All Non-Executive Directors had been in post for longer than two years.
- We identified that the Accounting Officer and Accountable Officer were not one and the same individual. In light of recent changes at the senior leadership level this role was split between David Sloman, CEO of another local NHS trust and between Ms McManus. We have been informed that this has since been altered following our inspection.
- Staff told us the trust executive management were a positive change to the organisation. They told us the executive team were visible and approachable and had resulted in a positive change to the culture within their short time in post.
- The organisation was managed through a structure of five Clinical Business Units (CBU's): Urgent & Emergency Care, Acute and General Medicine, Specialist Medicine & Support Services, Surgical Specialities and Women's & Children's. Each CBU was led by Clinical Director, who was supported by a range of Deputy Clinical Directors, Managing Directors, Heads of Nursing, Service Managers, Matrons and Clinical Service Leads.

Vision and strategy

- North Middlesex University Hospital describes it's vision for the organisation for the next 5 years as:
- To become the healthcare provider of choice for the diverse population we serve in north London and beyond, recognised for excellent emergency, acute, maternity and ambulatory care, delivered by excellent and compassionate staff.

Summary of findings

- The vision is underpinned by the following five strategic objectives:

1. To provide excellent clinical outcomes
2. To ensure positive experiences for patients and GPs
3. To be an employer of choice with efficient and compassionate staff and who act as ambassadors for the hospital
4. To provide services that offer good valu efor taxpayers
5. To develop the site so they can provide more high quality services for patients and staff, including education, teaching and learning

- Staff were aware of the trust's strategic objectives, however, many were unclear of the future of the organisation as the senior management team, including the director of nursing and chief executive officer, changed shortly before our inspection.
- The organization was part of Barnet, Enfield and Haringey (BEH) Clinical Strategy was implemented in 2013 to improve health services for local people in the three boroughs.This included launched it's the maternity unit to provide modern maternity services for the people of north and east Enfield and Haringey. In December 2013, it expanded its accident and emergency services to receive ambulance cases from north Enfield.
- In May 2016 the hospital and its local health partners in Haringey and Enfield launched the Safer, Faster, Better programme, which was created to look at the underlying causes behind ED delays and patients staying for long periods of time in the hospital. There are four different project groups looking at making improvements in flow, discharge planning and preventing admission in and out of hospital.
- Individual CBU's had local clinical strategies, however knowledge of these amongst staff were variable.
- We were told the last CQC inspection in April was a catalyst for change and this was seen in a very positive light. Senior managers said they felt excited about the future of the ED.
- During our last inspection, staff did not feel that the trust values were being upheld by the executive board and senior managers. Some told us at that time that they could not wear their lanyard with the trust values on them as they felt they were meaningless.

- We noticed a major shift in staff attitudes during this inspection. Most people we spoke with expressed a sense of optimism and a collective responsibility for the future success of the ED.

Summary of findings

- At the time of our 2014 inspection there was no non-executive lead for end of life care. At the time of our inspection, there was still no non-executive director, however the trust had sourced a candidate for this post but was yet to receive confirmation the position had been filled.
- There was no clear strategy for end of life care within the trust. This topic was discussed at the August 2016 End of Life Care Steering Group and a draft strategy was requested to be prepared in time for the next meeting.

Governance, risk management and quality measurement

- We found evidence of large programme of work to address the governance and risk management structures in the organisation. Monthly governance meetings had been implemented for each CBU along with monthly senior managers meetings. This system was in early in its' implementation, and not yet embedded having only achieved one cycle prior to our inspection.
- Risk registers were of variable quality across the different CBU's with some misalignment between the recorded risks on the risk register and the risks we observed. The Executive recognised that the new system of governance was not yet mature and different CBU's were at different levels of performance.
- Divisional meetings took place to review overall performance of the clinical areas. These meetings were described as punitive in nature, however since the introduction of the new executive team these had become more positive, mature conversations.
- The hospital used a quality monitoring dashboard which allowed effective monitoring of key performance indicators such as; safety thermometer data, theatre utilisation data, delays in access to diagnostic services, or in receiving treatment. It also monitored financial performance or staff related data such as training participation rate, vacancies, and temporary staff usage.
- We observed daily safety huddles in operation and clinical Key Performance Indicators (KPI's) were displayed on the wards.
- Within the ED . risks and incidents were discussed in two of these four weeks and the meeting was open to all clinicians and nurses.

Culture within the trust

Summary of findings

- Staff told us they believed there was a new culture of openness and transparency with the executive board. There were some concern expressed about the implications for staff in relation to the newly developed relationship with another hospital.
- Many staff had already met the new chief executive at least once since her appointment in July.
- Nursing staff told us that the new director of nursing, in addition to the assistant director of nursing made for a robust nurse leadership team, which modelled good working practices.
- We found there was a noticeable change in the culture of the ED since our inspection in April. Staff spoke with energy, enthusiasm and optimism about the future of their ED. They told us they felt they valued by their managers and believed they and had a voice with which to make suggestions and raise concerns without fear of being criticised for doing so.
- During our inspection a several members of staff in critical care contacted us on the condition of anonymity to raise concerns about bullying in the unit.
- The Executive management team had commissioned an independent consultation into staffing in critical care. We were also told that a new equality and diversity lead was in the process of starting a new trust-wide drive to improve working relationships and eliminate bullying and harassment.
- In maternity services the culture was not one of fairness, openness, transparency, honesty, challenge and candour. Staff we spoke with in the maternity service gave us examples of bullying, harassment and discrimination amongst the staff, at all levels. High levels of conflict were reported to us between certain groups of staff and staff were anxious about being be seen speaking with us. We were not assured that the culture was being managed effectively.
- Evidence of perceived bullying on the labour ward involving student and preceptorship midwives was provided to us. When asked about this, senior managers told us an investigation was ongoing and appropriate action would be taken dependant on the outcome.
- The Executive and Non-Executive teams were aware of the cultural issues present in both critical care and maternity services. The Director of HR had introduced a bullying and harassment pathway, whereby staff could contact a bullying

and harassment facilitator. Members of the Executive Team indicated felt there had been a positive cultural shift at the top of the organisation, but that it would take time in order for this change to impact all clinical areas.

Equalities and Diversity – including Workforce Race Equality Standard

- The Workforce Race Equality Standard (WRES) became mandated in the NHS Standard Contract 2015/16 and commissioning contracts. As a result NHS bodies were required to publish a WRES baseline report by 1st July 2015, based on a set of WRES indicators at April 2015. There are nine WRES indicators (refer to Appendix 1) of which four relate to workforce data; another four are based on questions from the NHS staff survey questions and one indicator relates to improving the ethnic composition of NHS Boards, better to reflect the population served. NHS bodies are required to produce WRES reports annually and demonstrate progress against these indicators of workforce race equality, thereby closing the gap between the less favourable treatment, opportunities and experience of the BME staff as compared to White staff.
- We found evidence of WRES reports being discussed and disseminated at Ward, CBU and Board level. The trust launched a new equality strategy in July 2015 and presented a new Diversity Scorecard via the trust Equality Impact Group in February 2016.
- We found that equality and diversity drives in the hospital were mainly focused on race and there was no structured support for lesbian, gay, bisexual or transgender staff.
- In both critical care and maternity services staff described culturally diverse teams and told us there were problems with team cohesion due to “competing beliefs and tribalism.” Staff reported that this affected their morale and ability to communicate effectively. A number of patients in maternity told us that they felt their concerns were not listened to because they were considered ‘white middle class’.

Fit and Proper Persons

- The trust had made preparations to meet the Fit and Proper Persons Requirement (FPPR) (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Regulation 5). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. The regulation came in to force in November 2014.

Summary of findings

- The trust had a fit and proper persons policy in place. This was a policy covering arrangements for both recruitment and ongoing assurance.
- As part of our 'Fit and Proper Person' we examined the personnel files for the five most recent members of the trust board. We found that two of the files were complete and had the correct documentation with a completed checklist to confirm that appropriate checks had been made for these two staff. However we found that for three members of staff who were on secondment and contractor agreements the files did not contain the relevant information. When we pointed this out to ,management we were informed that all the correct checks had been completed and they were held on files located at the secondees 'home' organisation.

Public engagement

- The ED's performance in the Friends and Family Test was consistently worse than the England average between September 2015 and June 2016. There was a steady decline in the percentage of people recommending the department which was consistently below 50%.
- CCU A patient, relative and visitor information board was on display at the entrance to the unit. This included details of how the unit had responded to feedback. For example, a new quiet lounge was being furnished that would include facilities to make food and drinks and senior staff were committed to improving communication through staff study days and multidisciplinary team training days.

Staff engagement

- We were told by staff that the executive team had arranged a number of social events as part of a strategy to engage staff more broadly and reduce a period of friction. This included an annual ball, a farewell party and a celebratory long-service party.
- We found that there were regular team meetings organised in most departments. Staff said these meetings were useful.
- We saw examples of different methods of staff engagement such as staff newsletter which informed them of trust-wide developments, as well as regular emails form the new senior management team sharing news and information on future developments.

- The trust organised a staff recognition scheme to appreciate "the hard work, dedication and commitment of staff and their efforts to improve services". The 'North Mid Star of the Month' award celebrated the contribution of staff and aim to recognise staff members who went the extra mile in their job.
- We heard reports in some departments of nepotism in recruitment, with staff telling us they felt opportunities for development and progression were offered on the basis of favouritism. They said they did not feel a transparent system of merit and professional competence was used when decisions were made about promotion.

Innovation, improvement and sustainability

- Through the inspection we identified that a number of staffing issues raised during the unannounced inspection of the ED had been resolved through short-term secondments of clinical staff into posts. We had concerns regarding the sustainability of these plans in the medium-term, and no clear plans were articulated to us around the sustainability of these secondments.
- In May 2016 the hospital launched the Safer, Faster, Better programme. This programme of work includes stakeholders from the across the local health economy to examine and resolve the underlying causes behind high ED attendances, waits in the ED and delays in transfers of care out of the hospital.
- The trust has launched the Outpatient Department (OPD) Transformation project. This group has been launched to address the main issues of concerns identified by patients, including: waiting times, car parking, missing medical records, short notice cancellations, over-booking of appointments, missing appointment letters, waits for medication and clinician punctuality. Patient journey mapping is being used as a diagnostic method in this improvement work.
- The hospital has worked to develop pathways where surgical patients could avoid admission and prolong hospital stay by involving the 'hospital at home' team and surgical assessment unit in their care. Many patients were referred directly to the SAU by their GP with a view to ease pressures on emergency department.
- The trust participated in the national pilot for on-line pre-assessment with a view to speed up a process, and improve patients' experience.
- The paediatric clinical teams used the SAFE programme. North Middlesex Hospital had been one of 28 hospitals which had

worked with the RCPCH in participating in a two year programme to develop and trial a suite of quality improvement techniques to improve communication, build a safety-based culture and deliver better outcomes for children and young people, known as SAFE. The SAFE programme was designed to reduce preventable deaths and error occurring in the UK's paediatric departments.

- As yet there is no frailty pathway in place in the ED, however this was recognised by the local leadership team, who voiced that there are a number of pathways which need to be developed in order to optimise patient flow through the ED.

Overview of ratings

Our ratings for North Middlesex University Hospital NHS Trust

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

Our ratings for North Middlesex University Hospital NHS Trust

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

Outstanding practice and areas for improvement

Outstanding practice

- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- Outpatient and diagnostic services had strong leadership. Staff were inspired to provide an excellent service, with the patient at the centre.
- The diagnostic imaging department worked hard to reduce the patient radiation doses and had presented this work at national and international conferences.
- The paediatric clinical teams used the SAFE programme. North Middlesex Hospital had been one of 28 hospitals which had worked with the RCPCH in participating in a twoyear programme to develop and trial a suite of quality improvement techniques to improve communication, build a safety-based culture and deliver better outcomes for children and young people, known as SAFE.The SAFE programme was designed to reduce preventable deaths and error occurring in the UK's paediatric departments.

Areas for improvement

Action the trust MUST take to improve

- The trust must code their complaints correctly to reflect palliative and end of life care complaints.
- The trust must send out bereavement surveys to the relatives of patients who have died within the hospital.
- The trust must produce and ratify an end of life care strategy.
- Ensure learning from incidents is more robust and shared with all staff.
- Ensure that all medicines and instruments associated with a resuscitation are disposed of safely afterwards.
- Ensure the renewal of advanced paediatric life support (APLS) certificates of those doctors and consultants whose certificates had expired
- Improve mandatory training levels for medical and nursing staff.
- Improve safeguarding adults level 2 training for medical and nursing staff.
- Improve safeguarding children level 2 training for medical and nursing staff.
- Improve hand hygiene levels to ensure consistency especially amongst medical staff.
- Ensure medical and nursing staff are fully trained and able to identify and support the needs of patients living with dementia.
- Ensure medical and nursing staff are fully trained and able to identify and support the needs of patients with learning disabilities.
- Improve appraisal rates of nurses.
- Ensure all actions in response to the never event are fully implemented.
- To analyse causes for higher than the national average mortality rate as suggested by the bowel cancer and the national hip fracture audit data.
- Carry out an audit of the stillbirth rate for the period Jan – Dec 2016 and develop an action plan to address themes.
- Provide one to one care in labour to all women.
- Replace all damaged equipment in Emergency Gyanecology Unit and triage.
- Monitor and report VTE compliance
- Monitor the temperature of medicines storage
- Carry out a review of culture within maternity and use tools such as 'walk in my shoes'.
- Review waiting times in triage and develop an action plan to address themes.
- Ensure mandatory training and multidisciplinary intrapartum care training targets are met.
- Display cleaning schedules or checklists all clinical areas.
- Ensure all staff observe the 'bare below the elbows' policy.
- Ensure patients have a named midwife.
- Ensure there are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up.

Outstanding practice and areas for improvement

- Ensure there are appropriate processes and monitoring arrangements in place to improve the 32 and 61 day cancer targets in line with national targets.
- Ensure there is improved access for beds to clinical areas in diagnostic imaging.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **End of Life Care** Systems and processes were not established or operated effectively to ensure the trust was able to assess, monitor and improve the quality and safety of the services provided. The trust did not effectively assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others. The trust did not assess, monitor and mitigate the risks relating to the health, safety and welfare of their palliative and end of life care patients. The trust did not code their complaints to reflect the concerns raised with end of life care. This meant that it is possible for complaints to be missed by the trust. This is a breach of regulation 17(2)(a) in which the provider must assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). The trust did not seek to gain feedback from patients or their relatives; therefore they were unable to act on this information. The bereaved relatives' survey had not been sent out since 2013; therefore, the trust could not identify areas of good practice or areas that required improvement. This is a breach of regulation 17(2)(e) in which the provider must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. There was no end of life care strategy at the time of our inspection.

This section is primarily information for the provider

Requirement notices

This is a breach of regulation 17(2)(f) in which the provider must evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).