North Middlesex University Hospital NHS Trust

Inspection report

Sterling Way
Haringey
London
N18 1QX
Tel: 02088872000
www.northmid.nhs.uk

Date of inspection visit: 27 September, 5 - 6 December 2023
Date of publication: 28/03/2024

Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

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

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

- We rated safe, effective, responsive and well-led as requires improvement, and caring as good.
- We rated the medical core services we inspected as requires improvement. This was requires improvement for safe, responsive and well led, and good for effective and caring.
- The rating of the well led assessment was requires improvement.
- In May 2023 we carried out an unannounced inspection of maternity services as part of the national maternity inspection programme. This rated safe as inadequate and well led as inadequate and the overall ratings for maternity services went down to inadequate.
- In rating the trust, we took into account the current ratings of the services not inspected at this time.

Well led assessment:

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

- Further work was needed to improve the culture of the trust with associated improved results in the NHS staff survey. Whilst the trust was largely a positive place to work, there were still services where staff interactions were not appropriate and where additional support was needed to achieve sustained cultural improvement. Where staff were not working well together this could have an adverse impact on the quality of patient care. In some cases, these teams had experienced difficulties for several years, or the services had improved but this had not been sustained. Whilst additional support had been provided in maternity, there was not enough appropriate support to other teams to achieve long term cultural improvements.

Our findings

- The investigations as part of formal processes to address HR issues, such as cases of bullying and harassment, were often taking too long and causing stress and anxiety to the individuals concerned. This was monitored but further work was needed to ensure sustained improvements.
- Whilst the trust had a leadership development programme, further work was needed to ensure staff managing front line services had received the development and support needed to perform their roles to a high standard. There were a number of staff, performing these roles who had recently been promoted and did not yet have the skills and experience to manage a busy service and support the staff team effectively.
- Although work had taken place to review the capability and capacity of the executive leadership team, an ongoing review will be needed to ensure senior leaders have the capacity to manage the changes needed as part of the ongoing work to merge with the Royal Free London group.
- Further input was needed for the trust's strategy to be embedded across all levels of the organisation. The Patient First Strategy used quality improvement as a delivery model and this approach needed to be understood and applied by staff across all levels of the organisation. Further developments were needed to the enabling strategies including the clinical and estates strategies to improve outcomes for patients.
- The trust needed to improve the timeliness of its complaint investigation work, incident investigations and mortality review work. This was important for patients, families and staff who are waiting to hear the outcomes of these processes. It was also needed to ensure any lessons learnt were shared to improve services for other people.

However:

- Leaders were committed and had an appropriate range of skills and experience to lead the and its services. They understood the priorities and issues the trust faced and were identifying actions to address them. We found that the trust was responding robustly to the findings of the maternity inspection report, and in partnership with external stakeholders was making improvements to the service. They were visible and approachable in the service for patients and staff. The board was reflective of the workforce population and community served.
- The trust was grounded and connected to the local community. This was reflected in the insight displayed of the needs of the diverse local population and the staff working at the trust. Trust leaders were active participants in the integrated care system and worked to improve the health outcomes for their local population.
- We found that all the leaders and staff we met were passionate and committed to delivering high quality patient care. The trust board and senior leadership team displayed sincerity on an ongoing basis. We found all the members of the board we spoke with to be open and honest during our inspection.
- The trust had effective structures, systems and processes in place to support the delivery of its strategy including board sub committees, divisional committees, team meetings and senior management meetings.
- The trust collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. There were a number of active patient groups such as, Maternity Voices, youth group and Achieving a Better Community (ABC) parents. There was evidence that these groups had taken patients' views into account in the design of services.

Our findings

- The trust has active staff networks which included, LGBT+, Ethnicity, Multi-Faith & Belief and the Women's Network. The chairs we positive about the trust's values and the leadership team's ability in promoting equality and fairness in the workforce. The group were particularly confident in the CEO and gave examples where she had shown a caring and supportive approach to staff concerns when they were raised with her.

Medical care service:

Our rating of this service at the North Middlesex University Hospital location stayed the same. We rated it as requires improvement because:

- The service did not always have enough staff to care for patients and keep them safe. This affected staff's ability to perform key tasks. For example, four-hourly observations were not always taken on time, patients who required repositioning to manage pressure ulcers were repositioned less frequently than advised by their care plan, or staff did not always undertake a follow up assessment for patients at risk of malnutrition.
- Not all staff had up to date training in life support. The trust did not confirm staff had training in the Mental Capacity Act, dementia awareness, and Deprivation of Liberty Safeguards. Not all staff were appraised by managers to ensure they were competent and to identify their development needs. This means staff were not always adequately supported to develop their skills.
- The service had delays in reviewing safety incidents and identifying learning lessons from them. The service did not operate an effective process for prompt identification of learning from deaths, they had many outstanding death reviews.
- Staff did not always follow systems and processes when safely prescribing, administering, recording, and storing medicines. We found that some patients may not have received their medication.
- The service explained delays in responding to complaints, they were frequently unable to meet the timelines set within the trust complaints management policy. This potentially delayed the identification of learning from complaints and making improvements.
- Managers did not routinely monitor if staff took prompt actions in response to sepsis. Staff did not always undertake a follow up assessment for patients who were at risk of malnutrition or obesity.
- Staff did not always plan discharges in advance to allow patients to plan ahead, to ensure all appropriate arrangements were ready when required, and to manage bed capacity effectively. Occasionally patients were transferred at night on short stay medical wards.

However:

- Staff understood safeguarding procedures and how to protect patients from abuse.
- The service controlled infection risk well.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them in making decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.

Our findings

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services using reliable information systems.
- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Trust wide – Well Led

Action the trust MUST take to improve:

- The trust must ensure that services where there is a poor culture are identified and offered appropriate support to bring sustained improvement. Regulation 17 Good governance
- The trust must ensure that staff in leadership roles have access to leadership development in a timely manner, particularly to ensure their people management skills are in place. Regulation 18 Staffing
- The trust must ensure that HR processes particularly in relation to performance are completed in a timely manner. Regulation 17 Good governance
- The trust must keep under review the executive leadership capacity to ensure the delivery of existing priorities and manage the merger with the Royal Free London group. Regulation 18 Staffing
- The trust must ensure that learning and improvements take place in a timely manner by ensuring the investigations into complaints, incidents and mortality are concluded within stated timescales. Regulation 17 Good governance.

Action the trust SHOULD take to improve:

- The trust should continue its work to ensure staff are trained in quality improvement approaches so they can embed the Patient First strategy in their services.
- The trust should continue its work to develop the enabling strategies – clinical and estates to promote improved outcomes for patients.

North Middlesex University Hospital – medical care

Action the trust MUST take to improve:

- The service must ensure medicines are available and administered as prescribed. Regulation 12 Safe care and treatment

Our findings

- The service must ensure vacant shifts are filled with appropriate staff so they can deliver the appropriate care for patients in line with their care plans and risk assessments and keep them safe. Regulation 12 Safe care and treatment and Regulation 18 Staffing
- The service must ensure that staff have completed training on meeting the needs of patients with dementia. Regulation 18 Staffing
- The service must ensure all staff has up to date training in life support. Regulation 18 Staffing
- The service must contribute to strengthening governance processes by supporting the timely completion of safety incident reviews, mortality reviews and complaints. The service must also ensure assurance checks are completed robustly and where needed improvements take place. Regulation 17 Good governance
- The service must ensure staff always plan discharges in advance to allow patients to make the necessary preparations, to ensure all appropriate arrangements are ready when required, and to manage bed capacity effectively. Regulation 9 Person-centred care

Action the trust SHOULD take to improve:

- The trust should ensure that all medicines are stored at the recommended temperature and managed in line with the provider's policy.
- The service should improve communication with staff regarding staffing decisions.
- The service should enhance medication management and reporting processes to prevent medication errors.
- The service should strengthen safety monitoring procedures, especially for high-risk patients. They should ensure routine observations are always taken on time, patients who required repositioning to manage pressure ulcers should be repositioned as advised by their care plan.
- The service should ensure staff have completed training in the Mental Capacity Act, and Deprivation of Liberty Safeguards.
- The service should to ensure all staff are appraised by managers to ensure they are competent and to identify their development needs.
- The service should routinely monitor if staff takes prompt actions in response to sepsis.
- The service should ensure staff undertakes a follow up assessment for patients who are at risk of malnutrition or obesity.
- The service should avoid patients' transfers at night.

Is this organisation well-led?

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

Leadership

Our findings

The trust board had the appropriate range of skills, knowledge and experience to perform its role effectively. We spoke with all six of the executive directors and all five of the non-executive directors (NEDs), and also the trust chair. We found that, as a whole, the trust board members had a variety of backgrounds and experiences from the private and public sectors. The chief nurse had only been in post for five weeks at the time of the inspection. We did not find that all NEDs were fully aware of the activities within the trust and their portfolio.

Leaders generally had the skills and abilities to run the trust and its services. They understood the priorities and issues the trust faced and were identifying actions to address them. They were visible and approachable in the service for patients and staff. They generally supported staff to develop their skills and take on more senior roles.

The board was reflective of the workforce population and community served. There were three Black and Minority Ethnic (BME) executive board members. Three of the executive board members were female. Of the non-executive board members, three (60%) were Black, Asian and ethnic minority and three (60%) were female.

Senior leaders were visible and approachable in the trust. There was a programme of board ('Gemba') visits to services which included hospital and community locations. Staff said that most executive and non-executive directors were very visible and approachable. There is an executive huddle each morning where current risks and pressures are focused on.

There was a range of skills among the non-executive directors. We talked with most of the trust's directors at length during the inspection about their specific areas of responsibility and more generally. We found that as a group, the board had extensive private and public sector experience.

The chairs of both the Audit Committee and the Finance Performance and Sustainability Committee were qualified to undertake the roles. Both had significant leadership experience in the finance function and within the NHS as non-executive directors; the Chair of the Finance, Performance and Sustainability Committee was an Associate NED at the neighbouring Royal Free NHS Foundation Trust and (amongst other roles within the trust) was also the Senior Independent Director.

Leaders understood the challenges to quality and sustainability and were identifying the actions needed to address them. Additionally, the trust had developed the view that the best way to ensure sustainability was to increase the depth of their relationship with the nearby Royal Free Trust. Leaders had started to work collectively to understand the challenges and identify actions they needed to progress this strategy.

We found that work had taken place to review the capability and capacity of the leadership team. However, as further leadership changes were taking place and the work with the Royal Free progresses, further consideration about the leadership capability and capacity was needed. For example, key staff described the challenges of undertaking their existing work relating to their portfolio's while undertaking increasingly demanding roles supporting the management of change related to the upcoming transaction with the Royal Free.

The Chief Financial Officer (CFO) was an experienced executive director who was also responsible for information technology and business intelligence. He had recently been appointed on secondment to lead the ICB's finance function, and it had been agreed that the deputy CFO would take on the role of interim director of finance.

The senior pharmacy leadership team provides leadership for medicines optimisation in the trust. There was good engagement with the trust executive and awareness of medicines optimisation challenges. However, challenges remain with regards to staff recruitment and retention. If not addressed this could create a risk to patient safety and care.

Our findings

The trust played a full role within the local North Central London (NCL) Integrated Care System. Senior members of the trust attended and, on occasions, took lead roles in NCL meetings. For example, they were playing a key role in developing cancer referral pathways.

Our observations and review of board meeting minutes demonstrated that there was variable challenge and scrutiny from non-executive directors. This could lead to decisions being made without proper scrutiny. We observed a trust board meeting during the inspection. During this meeting, all non-executive directors provided challenge and expertise in challenging issues discussed at the board. We saw that the chair promoted contributions from all members and the agenda balanced time effectively between quality, finance, performance and strategy.

The trust leadership team had a comprehensive knowledge of current priorities and challenges across all sectors and took action to address them. Most of the board members had a good knowledge of the key issues within the trust, even when they were outside of their direct portfolios. There was a regular cycle of board development days. It was clear that the board was acting 'as a whole' with an ongoing comprehensive discussion continually taking place.

We found the quality of leadership at divisional level to be generally good. However, below that level there were pockets of poor leadership. Many staff were in leadership roles for the first time. This was a potential reason for pockets of poor culture and staff experiencing harassment and bullying. This has been issue in the trust for a number of years and was identified at previous inspections and in annual NHS staff surveys. The issue has not yet been fully resolved.

Further work was needed to ensure staff managing front line services had received the development and support needed to perform their roles to a high standard. The trust had introduced a range of leadership development activities and training to develop staff at all levels. This covered topics such as leadership, appraisal training, absence and change management. This was still a new initiative and many junior managers had at the time of our inspection not yet had the opportunity to access this leadership training.

The trust had been running several tiered training programmes for all leaders including the Outstanding Leaders programme for clinicians, in Bands 7 and 8A. They had trained a total of almost 200 members of staff. Additionally, all managers were provided with a managers' induction course.

Our review of trust personnel files indicated that Fit and Proper Person checks were in place. The trust had a fit and proper persons policy which covered arrangements for both recruitment and ongoing assurance. This was in line with 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 into force in November 2014. As part of our 'Fit and Proper Person' review, we looked at five personnel files and checked that all of the relevant checks and paperwork had been completed. Our review showed that all the files had relevant checks in place as required by the policy.

Vision and Strategy

The trust had a vision which was 'to provide outstanding care for local people'. The trust wanted to deliver 'excellent outcomes for patients; excellent experiences for patients and staff; excellent value for money'.

We heard many examples of how the trust was grounded and connected to the local community. This was reflected in the insight displayed of the needs of the diverse local population and the staff working at the trust. Throughout the core service inspection, staff told us about the trust values of being caring, fair and open. These were displayed throughout the organisation and linked to the vision.

Our findings

The recently developed trust strategy was providing a helpful structure for the ongoing work of the trust. There was still a lot of work to be done to develop the systems and processes supporting the implementation of the strategy and engage front-line staff in the improvement work.

The Patient First strategy set out how the trust aimed to deliver on the vision titled 'True North'. The trust acknowledged that the strategy had been largely developed internally by the board and senior leaders. There had been limited input from people who use the trust services, staff and external stakeholders.

There were four strategic themes – partnerships; people; outstanding care and sustainability. Each of these strategic themes has an associated strategic initiative, corporate projects and breakthrough objectives with improvement plans for delivery which were a work in progress.

The Patient First strategy was underpinned by a number of enabling strategies including a clinical strategy. This was being reviewed and was going to the board in early 2024. It was hoped that the partnership with the Royal Free would offer opportunities for transformation – to strengthen patient pathways and improve service delivery and outcomes for patients.

During our inspection, we found that the estates strategy was not comprehensive, and its review was progressing at a slower rate than the clinical strategy. There was no vision for what the estates would look like in the long or in some areas the medium term. For example, a particular issue identified was the fact that some clinical areas were found to not be suitable for management of patients with respiratory infections in the trust during Covid and this meant that patients with these infections had to move to alternative wards. This limited the amount of isolation areas for care of patients with respiratory infections. There did not appear to be any forward plans or estates strategy to prioritise addressing this.

The Patient First strategy intended to use quality improvement as a delivery model for the strategy across the organisation and this approach needed to be understood and embedded across all levels of the organisation.

The trust were active participants in the work of the integrated care system and worked to meet the needs of the local communities. There were areas where work was underway but there was more to do. For example, the trust considering how the Enfield community services could integrate into their overall strategy and operate collaboratively with existing services run by the trust to maximise the benefits for patients. Another example was the trust's emergency department which had high levels of attendance partly due to the difficulties for local people being able to access primary care. Greater collaboration was needed by partners, including the trust, to explore capacity and pathways to ensure patients were treated in the right place by the right clinician.

At the time of the well led review there was a common and clear understanding at board level of the proposed transaction to work more closely with the Royal Free and the potential benefits. However, staff below this were less aware of the proposal. We found that there was a clarity among all staff we spoke with, from the board to the front line, that the trust was there to deliver good outcomes for their local community.

Culture

Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. The trust was working to promote equality and diversity in its daily work and provided opportunities for career development. The trust worked to promote an open culture where patients, their families and staff could raise concerns without fear. However, there were services where the culture needed to improve, and more support was needed.

Our findings

We found that all the leaders and staff we met were passionate and committed to delivering high quality patient care. The trust board and senior leadership team displayed sincerity on an ongoing basis. We found all the members of the board we spoke with to be open and honest during our inspection. They never took a defensive approach to issues we raised with them and were willing to acknowledge areas for improvement in a positive and constructive manner. Senior leaders did reflect that there were parts of the trust where the culture needed to improve and that they were not complacent.

The Freedom to Speak up Guardian (FSUG) arrangements through an independent service were working well and contacts with the service were monitored and had grown over the last couple of years. The FSUG was supported by director of human resources reporting to chief nurse. The FTSUG was accessible in the trust and had visited services where staff had raised concerns. Their details were advertised on posters and on the trust intranet page. Staff gave positive feedback about accessing the FTSUG and described them as visible and approachable within the trust.

We met with union representatives for staff in the trust. The executive team have monthly meetings with the unions. Most union representatives felt there was a good working relationship with the trust and that they were appropriately engaged. Union members highlighted that HR investigations were in several cases, taking too long. There were also unhelpful variations in the skills and experience of the different investigating staff member.

We heard that whilst the trust is largely a positive place to work there were still some pockets where staff interactions were not appropriate and where additional work is needed to achieve sustained cultural improvement. These issues had existed for a number of years and were still to be resolved by the trust. Whilst additional support had been provided in maternity there was not this level of support to other teams who experienced difficulties in team working.

Whilst we acknowledge the leadership program, we heard that some core managers needed further support to improve their capability so they can manage teams with confidence.

Senior leaders acknowledged that where the trust used formal processes to address HR issues, such as cases of bullying and harassment, these investigations were often taking too long and causing stress and anxiety to the individuals concerned. This was monitored but further work was needed to ensure sustained improvements.

Work was underway to promote equality, diversity, and inclusion but some of this was still at an early stage, with more to be done. For example, the trust had recently appointed a new associate director for health equity, diversity and inclusion to raise the profile of this work within the trust. The trust was committed to addressing racism and had developed an anti-racism statement and action plan. The trust was embedding a disability charter, and strengthening workplace adjustments for staff.

Prior to the inspection, we asked the trust to send out a survey to all its staff. The survey gave staff the opportunity to feedback directly to CQC via a secure link their thoughts about working in the trust. Unfortunately, we only received four staff responses which is too small a sample size to make any judgments.

The trust has regularly performed poorly in the NHS annual staff survey for a number of years. Of the 97 questions in the survey, the trust only scored better than the national average in 8 of them. With three examples being; Often/always look forward to going to work; Able to make improvements happen in my area of work; Appraisal helped me agree clear objectives for my work.

The trust was below the national average in 37 areas. With three examples being; Relationships at work are unstrained, Colleagues are polite and treat each other with respect, Never/rarely feel every working hour is tiring.

Our findings

Despite a number of initiatives, the trust has failed to significantly improve its performance in the national survey for a number of years.

Equality and diversity were promoted within the organisation, with clear leadership from the board. The trust had a very diverse workforce. As of March 2023, the trust reported that 67% of the workforce were from Black, Asian and minority ethnic(BAME) backgrounds. The trust board and senior leadership team was reflective of the workforce and the community.

The Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) reports for the trust demonstrated there was a good level of diversity in senior leadership posts. The WRES results found that more BAME staff believed there were equal opportunities for career progression and there had been a decrease in the likelihood of BAME staff entering formal disciplinary procedures. However, there had been an increase in the likelihood of white applicants being shortlisted compared to BAME applicants.

Patients and their families were able to raise concerns with the trust. The trust had a complaints policy in place, as well as a policy in relation to Duty of Candour. Our review of complaints and serious incident investigations demonstrated that the process for making a complaint was appropriate. Investigations were generally thorough, outcomes explained, including any learning/actions from concerns raised. The main themes from complaints included poor communication by staff, missing information and miscommunication, and staff behaviours and attitudes. The divisions organised weekly complaints tracker meetings with handlers and divisional complaints reviews to ensure complaints were reviewed and responded to promptly. The divisions monitored if responses were provided promptly and within the timeline set by the organisational policies. However, the trust has not met its own target for dealing with complaints in a timely way since August 2021. During our inspection, we were not confident that there was a resourced plan in place to resolve this issue.

Governance

Leaders ensured effective governance processes, throughout the service and sometimes with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The trust operated from a site in Edmonton. Its estate had been enhanced by modern privately financed (“PFI”) hospital facilities. The trust had worked in partnership with other NHS providers in North Central London, particularly the Royal Free NHS Foundation Trust, and benefitted from a range of shared back-office support services, including estates and facilities; procurement; payroll and recruitment services. It had recently assumed responsibility for Enfield Community Services.

The trust had effective structures, systems and processes in place to support the delivery of its strategy including board sub committees, divisional committees, team meetings and senior management meetings. All members of the board had good attendance at governance meetings and gave clear leadership and direction. The board functioned effectively both inside and outside of formal meetings.

The trust had four key committees, each chaired by a non-executive director. These were; Finance, Performance and Sustainability Committee, Audit Committee, Quality Committee and the People and Culture Committee. We found that the system generally functioned well with appropriate issues being escalated to the full board. The committee chairs were generally competent in their roles providing the correct levels of challenge, support and direction.

Our findings

There were monthly Strategic Development Review meetings between executive board members and divisional leadership teams. The meetings reviewed performance using a score card which included the appropriate data to inform discussions. Arrangements had been made to closely monitor the progress of the maternity department, including external partners following the recent CQC inspection where the service was rated inadequate.

Medicines optimisation was well integrated into the trust governance structure and there was no evidence of gaps in the reporting structure between different committees. Medicines incidents were reported through an electronic recording system, and audits were routinely conducted by the pharmacy team and results shared and actions implemented by the appropriate governance committee.

At the time of the inspection, the trust had recently completed a review of its financial forecasts and was on track to deliver its break-even financial plan within the ICB. It told us that it had set a savings target of £18.4mn for 2023-24, of which £15mn should be recurrent; and £3.4mn through non-recurrent vacancy factors. The trust told us that it had identified opportunities of c£14.2mn, but that it was seeking additional schemes to reduce the forecast gap of £3.5mn.

The terms of the trust's PFI contract meant that close liaison was required between the trust; the PFI funder and its contracted facilities management providers.

The trust told us that it had recently agreed contract changes to ensure that all facilities management staff managed by outsourced providers would be paid the London living wage; and would bring in-house cleaning and catering staff with effect from February 2024.

The quality of financial training and staff development had been recognised by healthcare professional peers by the award to the trust of the HFMA Havelock award for 2023.

External Auditors Grant Thornton had given an unqualified opinion on the 2022-23 accounts, including the value for money opinion covering arrangements for securing value for money; governance and financial sustainability. The trust's internal audit provider KPMG had given its opinion that it had "significant assurance [about the operation of controls] with minor improvement opportunities." This indicates the trust has appropriate review and control methods in place and has received a positive professional report.

At the time of the inspection, the trust expected that it would receive c£480m income to provide services in 2023-4 and would deliver a small surplus financially. It expected to invest c£17.2m in improving its equipment; estates; and digital assets, through its capital expenditure limit and national programme schemes. It told us that the trust's investment requirements meant that it was vigilant in submitting applications for addition external funding and had been successful.

Management of risk, issues and performance

Leaders and teams generally used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Our findings

The Board Assurance Framework (BAF) sets out the principle risks to delivery of the Patient First Programme and the five strategic objectives for the trust. Each strategic objective in the Patient First programme had clear goals and measures to be met through the trusts quality improvement approaches. The introduction to the BAF states clearly that this is a tool that articulates the principal risks to delivery of the trust strategic objectives and the actions being taken to mitigate this.

Each BAF risk set out the plans for delivery clearly embedded in the Patient First Programme and associated corporate projects. It included the controls and assurances in place and the gaps in these and mitigating actions. It included the relevant risks on the Significant Risk Register (SRR) to delivery of each strategic objective. It was clearly set out and fit for purpose. Our review of the BAF and interviews with executive leaders demonstrated that there was effective oversight and assurances in place for each strategic objectives.

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. However, delays in investigating incidents and complaints could impact on the timeliness of learning lessons. The governance team regularly reviewed these systems. Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance.

The trust board had sight of the most significant risks and mitigating actions were clear. We found that there was a clear culture of risk identification and reporting throughout the organisation. Staff concerns matched those on the risk register. Staff and committee chairs we spoke with shared a common understanding of the trust's key risks and what mitigation was taking place to reduce them. Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed.

We reviewed the trust's strategic risk register (SRR) in detail. The introduction to the report set out the governance arrangements for risk management with reviews of risks and mitigating actions being undertaken. The trust risk management group reviewed new risks, challenged and approved downgraded or upgraded risks. The SRR clearly was a dynamic document driving a reduction in risk. We found that risks could have been better articulated in terms of risk and impact to patients but the process was robust and fit for purpose. The medicines optimisation risk register was managed by the pharmacy senior leadership team, and key performance and quality of pharmacy service were monitored via standard trust set KPIs.

One of the major risks was the flow through the Emergency Department. Safety was a priority in addressing this risk and effective escalation processes were in place as demand increased. For example, increasing staffing levels and asking for support from ICS partners. The trust was able to manage day to day issues using its 'go for flow' approach which through 5 daily bed meetings maximised the flow of patients through and out of the hospital. The other major risk regularly mentioned by leaders was the performance and safety of the maternity unit. Leaders were aware and recognised the risks identified at the recent CQC inspection of maternity.

The trust senior leaders were positively engaged with quality and safety. Incidents were reviewed daily by the divisional governance managers. More serious incidents triggered a rapid review process which was scrutinised by the weekly governance review panel. Incident management was monitored at several monthly forums such as divisional meetings, patient safety group, and quality governance committee. There was a '7 minute' learning process to implement immediate learning prior to completion of any full investigations.

Our findings

The trust had performed well in ensuring staff completed mandatory training. Whilst there were some areas, such as resus and paediatrics, where performance still needed to be improved. Life support training was an area for improvement. The overall position was favourable with the trust consistently performing above its 85% target. In areas where improvements were required there were actions plan in place.

Mortality data was reviewed at monthly meetings chaired by the medical director. All deaths were reviewed by the trust's medical examiners. The trust had a backlog of mortality cases that were awaiting structured judgment review, which was highlighted by the divisional mortality review committee that met quarterly. In August 2023, there were over 1000 cases that awaited closure of the structured judgement review process. This meant that the service potentially delayed opportunities to identify and implement learning from deaths. After the inspection the trust told us their standard operating procedure (SOP) prescribed a routine review of 25% of deaths (category B; i.e. mortality alerts, community deaths, post discharge deaths,). This was written when the process was new and there was a minimal guidance on the number to be reviewed. The trust felt this number was higher than at other NHS trusts and had a resource implication. The trust told us they had recently changed their standard operating procedure to reflect the national guidance and peer approach.

The trust had safeguarding policies for adults and children in place.

Information Management

The trust collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff said they had access to all necessary information and were encouraged to challenge its reliability. Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care.

The trust was aware of its performance through the use of key performance indicators and other metrics, they were in the process of standardising the information and dashboards used across the clinical divisions. This data fed into a governance framework. Information was in an accessible format, timely, accurate and identified areas for improvement. The data provided at the board level allowed a direct comparison and could be used to support a better understanding across the teams and divisions.

The ongoing move of patient records from paper to electronic has given the trust a number of opportunities to share and use data more effectively. Firstly, in terms of better patient pathway tracking and monitoring as patients move around the hospital and also in the ability to create an ongoing 'shared care record'.

The trust has a chief pharmacy information officer that sits in the trust digital team, who reviews risks flagged by medication safety officer (MSO) or Datix in relation to information systems. These were then feedback to systems providers to help facilitate improvement.

We were impressed with some of the developments which had taken place with digital technology and the associated production of accurate and timely information. Staff now had access to a system that could analyse and report on data from multiple critical systems and provided information, which would previously had taken days to be available, in hours.

Our findings

The trust still had more work to do on making sure that all its data was reliable. This included clinical pathways and clinical recording data. The trust had tasked the data quality working group to monitor this risk.

The trust was well protected from external cyber-attacks. A recent independent audit had found 'significant assurance'. They were following and compliant with the NHS Data Security and Protection Toolkit.

The board received information on service quality and sustainability. The data available to inform decision making was easy to understand and appropriately signposted key risks to both the executive team and the nonexecutive directors.

Leaders submitted notifications to external bodies as required. CQC and external bodies, such as the Integrated Care Board and NHS, found the trust to be open and had informed them of any issues they were required to report. Reports and investigations were submitted to CQC promptly and were thorough and robust.

Staff had access to the IT equipment and systems needed to do their work. IT systems and telephones were working well, and they helped to improve the quality of care. The trust had a capital programme which included IT equipment exchange. Leaders understood that staff needed to be provided with efficient IT systems to improve productivity and ensure good and effective patient's care and treatment delivery.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They sometimes collaborated with partner organisations to help improve services for patients.

The catchment area for the trust was one of the most diverse communities in the country, this was coupled with significant health inequalities. Less than a quarter of the local population described themselves as British. In addition, the area had high levels of deprivation and low healthcare outcomes including overall life expectancy.

The trust had a close working relationship with the neighbouring Royal Free Group. There had been several initiatives to increase shared services such as finance and HR which had provided benefits to both trusts. The trust also worked well with other system partners across North Central London for the benefit of patients.

The medicines optimisation team collaborated with colleagues in adjacent trusts through networking groups. Non-medical pharmacist participated in pharmacist led clinics and provide in depth support to patients and regular training updates to staff.

The national Friends and Family test for inpatients over the last two years had performed above the national average with an average of 93% of patients saying they would recommend the trust. However, for ED patients the rate was 60%. The trust struggled to secure high response rates from patients despite a number of initiatives.

We understand that the Patient Council was starting but believe that further work was needed to ensure effective engagement with patients and carers.

The trust had a structured and systematic approach to engaging with patients, those close to them and their representatives. Patients, staff and carers were able to meet with members of the trust's leadership team to give feedback.

Our findings

There were several active patient groups such as, Maternity Voices, youth group and Achieving a Better Community (ABC) parents. There was evidence that these groups had taken patients views into account in the design of services. The trust also used 'patient story's' at the beginning of their meetings to improve engagement.

We met with the chairs for the staff networks which included, LGBT+, Ethnicity, Multi-Faith & Belief and the Women's Network. The chairs we positive about the trust's values and the leadership team's ability in promoting equality and fairness in the workforce. They gave a number of examples where executives and NEDs had promoted positive values and supported staff and the networks. The group were particularly confident in the CEO and gave examples where she had shown a caring and supportive approach to staff concerns when they were raised with her. The chairs met regularly with board members and felt listened to and valued.

The trust had a steady staff vacancy rate at around 10%. We found numerous examples where the trust was working to recruit staff both in the UK and abroad. The trust was a local 'anchor' organisation and worked well with its community to provide them with work and development opportunities at the trust.

Learning continuous improvement and innovation

All staff were committed to continually learning and improving services. They were developing a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The trust took appropriate action as a result of any learning from concerns raised. The trust had effective systems for learning from deaths, serious incidents and other incidents. The trust actively sought to participate in national improvement and innovation projects. However, there were further opportunities to develop clinical research within the trust.

The quality of financial training and staff development had been recognised by healthcare professional peers by the award to the trust of the HFMA Havelock award for 2023.

The pharmacy leadership team explained that continuous learning, improvement, and innovation was sustained by the pharmacy team involvement in clinical services and infrastructure improvements such as installation of a pharmacy dispensary robot, as well as introduction of satellite pharmacy on ward.

Achieving a Better Community (ABC Parents), provided childhood illness and injury education, resuscitation skills, community drop-in groups, workshops and peer support to increase parental knowledge, build confidence and encourage appropriate engagement with healthcare resources. By working collaboratively to empower families and tackle barriers to community engagement, the project's multidisciplinary approach, in partnership with various local organisations, fostered a community of resources for families, with a network of trained Parent Champions.

A key feature of the programme was the recruitment of "Parent Champions" who were integral to the delivery of sessions and the development of peer-networks. To date, 40 Parent Champions had been recruited and trained, of which 31 remained active in the programme. In addition, 11 Breastfeeding Helpers trained by The Breastfeeding Network were providing peer support and lead on community engagement. ABC Parents had delivered over 3000 instances of training and support.

The trust had worked closely with patients with red cell disorders to ensure they delivered care that met their needs. They held 3 open meetings led by the Chief Executive and Medical Director with patients with sickle cell and thalassaemia following the tragic death of a young sickle cell patient. The purpose of these meetings was to rebuild trust

and understand what their key priorities were for improving trust and services. Following these meetings, a patient panel was set up and an improvement lead appointed to support the transformation work. Key interventions in response to the views of the patient panel included a refurbishment and redesign of the George Marsh Centre which offered community support for patients. In addition, the opening hours of the haematology day unit had been extended to enable patients to have automated red cell transfusions in the evenings and weekends, reducing the impact on their working lives.

The trust led engagement with the North Central London Red Cell Improvement Group and advocacy groups, such as Sickle Cell Cause. They identified the need to improve the speed with which patients in a painful crisis receive pain relief. The trust successfully bid for funding from NHS England to be a pilot site for an emergency care bypass model for patients with red cell disorders who require treatment for painful crises. Five patients were part of the steering group who were coproducing the project. The trust hosted a successful event in July 2022 at Tottenham Hotspurs Football club for 450 children and families from across NCL who were living with Sickle Cell Disease. This focussed on their wellbeing and possibilities for new treatments including gene therapy.

The trust set up a Youth Forum in November 2021 with 5 young people, who were all service users. It was set up by the Hospital Play Specialists with the support of the Associate Director of Nursing for Babies, Children and Young People and a Practice Development Nurse. The objective was to collaborate informally with young people to understand their perspectives of the service they receive from the trust and how they could work together to improve services. In 2021 and 2022, the young people met about 6 times and as a result, identified several key issues that they wanted to focus on, for example: inconsistent internet connection; limited food options; recreational activities; pet therapy; beds for parents to sleep when staying overnight with 16–18-year-old patients on adult wards. They completed a 15 steps challenge walkaround of all the inpatient paediatric areas to further inform the areas they wanted to work on and gave feedback particularly around the environment providing décor and resources for all age groups. As a result, the trust improved food menus, introduced pet therapy and improved internet connectivity.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Mar 2024	Requires Improvement →← Mar 2024	Good →← Mar 2024	Requires Improvement →← Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement →← Mar 2024

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
North Middlesex University Hospital	Requires Improvement →← Mar 2024	Requires Improvement →← Mar 2024	Good →← Mar 2024	Requires Improvement →← Mar 2024	Requires Improvement →← Mar 2024	Requires Improvement →← Mar 2024
Overall trust	Requires Improvement →← Mar 2024	Requires Improvement →← Mar 2024	Good →← Mar 2024	Requires Improvement →← Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement →← Mar 2024

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

Rating for North Middlesex University Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement →← Mar 2024	Good ↑ Mar 2024	Good →← Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement →← Mar 2024
Services for children & young people	Requires improvement Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Requires improvement Oct 2019	Requires improvement Oct 2019
Critical care	Requires improvement Sep 2018	Good Sep 2018	Good Sep 2018	Good Sep 2018	Good Sep 2018	Good Sep 2018
End of life care	Requires improvement Sep 2018	Requires improvement Sep 2018	Good Sep 2018	Requires improvement Sep 2018	Requires improvement Sep 2018	Requires improvement Sep 2018
Surgery	Good Sep 2018	Good Sep 2018	Good Sep 2018	Requires improvement Sep 2018	Good Sep 2018	Good Sep 2018
Urgent and emergency services	Requires improvement Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
Maternity	Inadequate Dec 2023	Good Sep 2018	Good Sep 2018	Good Sep 2018	Inadequate Dec 2023	Inadequate Dec 2023
Outpatients	Requires improvement Sep 2018	Not rated	Good Sep 2018	Good Sep 2018	Requires improvement Sep 2018	Requires improvement Sep 2018
Overall	Requires Improvement →← Mar 2024	Requires Improvement →← Mar 2024	Good →← Mar 2024	Requires Improvement →← Mar 2024	Requires Improvement →← Mar 2024	Requires Improvement →← Mar 2024

North Middlesex University Hospital

Sterling Way
Haringey
London
N18 1QX
Tel: 02088872000
www.northmid.nhs.uk

Description of this hospital

The North Middlesex University Hospital NHS Trust is a medium-sized acute trust with 633 beds, and employing just under 4000 staff (over half living in the local community); serving a population of around 640,000 people living across Enfield and Haringey. The trusts turnover in 2022/23 was £442.5m.

The trust's services are provided at the North Middlesex University Hospital (NMUH) main site as well as a range of other hospital and community sites in the boroughs of Enfield and Haringey. They deliver services in collaboration with a range of partners, including local GPs, acute and mental health providers, and other community health service providers across North Central London.

The trust is part of North Central London integrated care system which brings together the NHS organisations and local authorities to meet the health and care needs of people in Camden, Islington, Barnet, Enfield, and Haringey. The community served by the trust is one of the most diverse in London and has high levels of deprivation. The trust is working with system partners to reduce health inequalities.

NMUH is a training unit for medical students from University College London and St George's University Grenada (West Indies), and for nursing and midwifery students from the Middlesex University and many others.

The trust provides a full range of adult, elderly, and children's services across medical and surgical disciplines. It has some specialist services such as HIV, cardiology, blood disorders, diabetes, fertility, sickle cell and thalassaemia. In April 2023 the trust had taken on the provision of community health services in Enfield such as district nursing, with 600 staff joining the trust.

The majority of clinical activity happens at the main North Middlesex Hospital site. The trust also has an outpatient clinic at St Ann's hospital, for sickle cell and thalassaemia, in Tottenham. The most recent addition is a step-down ward at Chase Farm (nursing led care with input from GPs). The trust offers integrated sexual health services in Enfield in partnership with the London borough of Enfield. The clinics offer free and confidential sexual health screening and/or treatment and general advice to all patients regardless of their age, sexuality or where the patients live.

This inspection covered the medical care core service provided by the trust and also looked at whether the trust was well led.

Our findings

The trust has over 421 medical inpatient beds across 20 wards, mostly located at North Middlesex University Hospital. The trust has two wards located at the Chase Farm Hospital.

Medical specialities providing inpatient care are:

- Acute medicine with ambulatory care
- Cardiology with catheter laboratory and outpatient service for heart failure and arrythmia, rapid access chest pain and full range of cardiology technical services
- Respiratory medicine, which includes a full range of diagnostic services including bronchoscopy and endobronchial bronchoscopy, a large tuberculosis cohort and cancer care
- Gastroenterology services include hepatology and endoscopy, including consultant rota 24 hours a day seven days per week
- Care of the elderly - day hospital and community and care home services
- Diabetes and endocrine including outpatients and diagnostics
- Haematology and anticoagulation - large tertiary cohort of haemoglobinopathy patients
- Stroke unit with transient ischemic attack (TIA) clinic
- Oncology services.

Admissions for the top three medical specialties were: general medicine (43%), gastroenterology 30%, clinical oncology (27%).

How we carried out this inspection

We carried out the medical care (including older people's care) core service inspection unannounced on 27 September and the well-led trust overall inspection announced on 5 and 6 December 2023. We inspected medical care because it is the trusts largest service and there had been concerns about sickle cell and elderly care raised with CQC. We also undertook a well led inspection because concerns had been raised with CQC by a number of staff members about the overall trust culture.

We visited areas relevant to the core service inspected and spoke with several patients, staff, and patient representatives. We spoke with staff at all levels of the organisation including healthcare assistants, nurses, junior doctors, pharmacy staff, consultants and administrative staff.

We also looked at a wide range of documents including policies, standard operating procedures, meeting minutes, action plans, risk assessments, training records and audit results. We attended staff handovers and safety huddles.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Medical care (including older people's care)

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

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

Mandatory Training

Although the overall target for the completion of mandatory training was achieved by the department, some staff had not completed mandatory training in key areas.

The mandatory training offer was comprehensive and met the needs of patients and staff. It included health and safety, fire safety, moving and handling, information governance, and life support training amongst others.

Managers monitored mandatory training and alerted staff when they needed to update their training. The trust set targets for mandatory training completion that depended on the subject and varied between 85% and 95%. The overall target for the completion of mandatory training was 85% and records indicated the overall target was met. However, the trust did not provide data related to different staff groups and individual wards. This meant we were unable to assess if any groups or specialities performed better than others.

Training records also indicated not all required staff received adequate life support training with training rates declining between May and October 2023. The department failed to ensure that at least 85% of staff had up to date life support training.

Only 38% of staff at the trust level received dementia awareness training. The trust did not provide information for specific medical wards.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific to their role on how to recognise and report abuse. The training participation rates were above the target set by the trust for safeguarding training participation.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff received training in equality, diversity, and human rights.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the wards.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. In general, the hospital, including medical wards performed well for cleanliness in PLACE audits (Patient-Led Assessments of the Care Environment). The service generally performed well for cleanliness as confirmed by the internal audits carried out by the ward staff.

Adherence to infection prevention and control principles (IPC) was also monitored at the ward level through monthly audits. Those audits demonstrated overall good compliance with IPC standards on medical wards.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff received IPC training. Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

The service monitored serious infection rates (including sepsis and antimicrobial) at the ward level. The information provided by the hospital indicated there were no major outbreaks of infections on medical wards.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. Staff undertook regular comfort rounds when they checked if patients had call bells within reach.

The design of the environment followed national guidance. Although the hospital performed well in the PLACE audit reviewing condition, appearance, and maintenance they did not share data specific to medical wards. The division prepared a brief action plan to respond to a few areas of concerns identified in 2022 and indicated all have been addressed. Other environmental audits identified only minor concerns for the medical ward and overall had positive findings.

Staff carried out safety checks of specialist equipment. They reported they had enough suitable equipment to help them to safely care for patients including when specialist equipment was required.

The service had suitable facilities to meet the needs of patients' families.

Staff disposed of clinical waste safely.

Medical care (including older people's care)

Assessing and responding to patient risk

There were occasional delays in completing and updating individual risk assessments. Staff were not always able to respond to patients' needs in line with their individual risk assessments.

Staff used a nationally recognised tool to identify deteriorating patients and escalate them appropriately. The hospital used an electronic observation and decision support system designed to improve patient safety and outcomes. It monitored and analysed patient vital signs to identify deteriorating conditions and provide risk scores to trigger escalation pathways. It carried out an audit of how well staff used the tool and if observations were taken by staff on time. The audit indicated that four-hourly observations were not always taken on time in September and October 2023. Often, they had been delayed by more than 25 minutes and in some cases by more than 80 minutes. Most of the medical wards did not meet the trust's target of 90% of observations being completed on time.

Training records indicated that not all required staff received adequate life support training with training rates declining between May and October 2023.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. However, they were not always able to ensure all shifts were fully covered as planned. This occasionally resulted in staff not being able to respond to patients' needs in line with their individual risk assessments. For example, although staff repositioned patients at risk of developing pressure ulcers at regular intervals it was less frequent than advised by the tissue viability nurse and the individual care plan.

The service monitored the number of falls experienced by patients on medical wards, they had falls reduction initiatives that were meant to improve the support offered to patients at risk of falls. Wards with reported greater than 10 falls per 1000 bed days included Amber, Topaz, and Acute Stroke Unit. The service reviewed where patients at risk of falls were located and used cohort areas with increased staff monitoring to reduce the risk of falls.

Malnutrition Universal Screening Tool (MUST) is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan. It is for use in hospitals, local communities, and other care settings and can be used by all care workers. MUST audits for medical wards indicated that the assessment has not always been completed within the 6 hours of admission as aimed by the trust (66%). All hospital inpatients on admission should be screened as recommended by the national guidance (Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition). Screening should be repeated weekly; however, the audit data provided by the trust indicated that in the majority of cases, no follow up assessment was undertaken (62%).

Staff knew about and dealt with any specific risk issues. They were aware of how to recognise sepsis and received suitable training to do so. The trust audited if staff on medical wards took prompt action in response to sepsis.

The trust monitored if staff prevented infections that could develop because of non-adherence to guidelines for the prevention of intravascular catheter-related infections. An audit of cannula insertion and ongoing care, undertaken in June 2023, indicated that not all staff complied with required standards and on occasions, they did not document the cleansing solution used during insertion or the lot number of the device. We noted that compliance rates varied between medical wards with some wards scoring well. The department agreed on actions taken in response and they were looking to re-audit in six months.

Medical care (including older people's care)

The service had access to a critical care outreach team which provided 24-hour 7-day specialist service. They could contact them via the bleep system and the team consisted of staff that had experience in advanced critical care management. Staff reported the team was responsive to patients' needs when they contacted them.

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not have enough nursing and support staff to keep patients safe. The number of nurses and healthcare assistants did not always match the planned numbers. This raised concerns about the hospital's capacity to maintain safety standards during periods of staff scarcity. Staff told us the hospital was very frequently operating under 'amber' alert, including during our inspection. This meant there was a shortage of one nurse per ward and some health care assistants (HCAs). This shortfall potentially increased risks to patient safety. Documents confirmed that staffing levels were inadequate with most of the medical wards on most days being short of one nurse and on occasions all the medical wards being short of one registered nurse during daytime (July to September 2023). Shifts' fill rates were slightly better at night with more shifts being accurately staffed by registered nurses and healthcare assistants.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. The trust carried out six monthly reviews of staffing establishment with the latest review carried out in September 2023. Although the review highlighted some areas of risks, where staffing levels could have an impact on the quality of care, it concluded that the staff establishment for medical wards was to remain the same. Pearl, Amber, Emerald, and Topaz ward, and the Acute Medical Unit raised most of the red flag events for the medical division. Red flag events occur when there is an omission in care or if there is a significant shortfall of registered staff (The National Institute for Health and Care Excellence guideline Safe staffing for nursing in adult inpatient wards in acute hospitals, 2014). Staffing establishment review noted an increase in the number of red flags events on those wards and overall, for all inpatient areas when compared with a similar review completed by the trust in May 2023. The quality concerns were addressed through the development of local action plans.

The ward manager could adjust staffing levels daily according to the needs of patients. The staffing establishment was set to support a minimal ratio of one registered nurse to eight patients during the day but was dependent on the management of staff rosters, absences, and vacancies.

The trust reported increasing vacancy rates amongst their nursing staff (5.4%, June 2023), with moderate to high vacancy rates at the divisional level. They reduced the turnover rates for nursing and HCA staff between June 2022 and June 2023 (approximately from 15.5% to 13.5%). Acute stroke unit, wards T4, T8, and Topaz noted high vacancy, turnover, and sickness rates in 2023.

The service had low rates of bank and agency nurses used on the wards. Managers limited their use of bank and agency staff and requested staff familiar with the service. When bank staff were required, the trust relied on its bank staff rather than agency workers. Ward staff told us frequently it was difficult to fill shifts with bank or agency staff as they observed delays in the planning and approval process making it difficult to find staff due to the short notice. Senior staff felt they could get approval to fill shifts on time.

Medical care (including older people's care)

Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. However, there were gaps for some of the specialities that could occasionally impact the smooth running of the service. Those were noted on the divisional risk register and included specialities such as cardiology, respiratory, gastroenterology, and consultant geriatrician gaps amongst others. The service also experienced problems with filling gaps on the staffing rota due to low rates of bank staff available to cover them.

Staff at the Acute Medical Unit (AMU) expressed concerns about not being fully informed regarding staffing decisions. AMU's rounds were frequently delayed as the doctors were required to partake in a ward round at the same-day emergency care service. The Same Day Emergency Care (SDEC) unit provided consultant and advanced care practitioner-led care for patients referred with acute medical conditions. Staff said this caused delays in discharge decisions being taken and affected the flow of the AMU.

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff. They often used regular locum staff to ensure they were familiar with the service. Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Staff undertook monthly clinical records audits to verify the completeness and overall quality. Audits indicated overall good compliance with the expected standard.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines

Staff did not always follow systems and processes when safely prescribing, administering, recording, and storing medicines.

Medical care (including older people's care)

The trust had an electronic prescribing and medicines administration system (EPMA) which improved the prescribing of medicines. However, during the inspection, we looked at 14 patient records over three medical wards. Three people had several missed or omitted doses of medicines. On one occasion, it was documented that the medicines were not available out of hours, and on three occasions, staff told us that there was a possibility of these medicines being administered by a night nurse who forgot to sign the record. Therefore, nurses on the day shift would document on patient records "administered by the previous shift" after ringing the night nurse at home. One person appears to have missed a critical medicine.

Clinical pharmacy services, medicines advice and supplies were available from the pharmacy team. An on-call pharmacist was available outside of core working hours. Staff told us that they knew how to contact the pharmacy if required. Although on occasions we noted that patients' missed doses were due to medicines not being available, there was no evidence that the on-call pharmacist was contacted.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines.

Venous thromboembolism (VTE) protocols were embedded into the electronic prescribing system meaning patients were automatically screened for their VTE needs and then prescribed appropriate medicines.

On the acute medical unit, pharmacists and pharmacy technicians were ward-based and provided a regular clinical review of all medicines prescribed. Medicines were promptly dispensed on the ward and readily available to patients.

Staff did not always store and manage all medicines and prescribing documents in line with the provider's policy. Medicine storage areas and electronic records could only be accessed by authorised staff using swipe cards, keypads, and individual logins. Medicines were stored securely, including controlled drugs (CDs). However, medicine was not always stored at appropriate ambient room temperature to ensure they remained stable and effective to use. On all three wards visited, we found gaps in temperature monitoring and persistent high temperatures above the manufacturer's recommendation. Staff told us that these have been escalated on several occasions and we saw they reported it.

Staff followed current national practice to check patients had the correct medicines. Staff carried out a comprehensive medicines’ reconciliation of patients' medicines on admission to the wards in line with NICE guidance (The National Institute for Health and Care Excellence).

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The medicines safety officer provided a monthly medicines newsletter which was distributed widely across the trust. It was displayed in treatment rooms and specific areas of concern surrounding alerts and information on incidents.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff we spoke with could describe what they would do when someone refused their medicines and lacked mental capacity.

Incidents

Medical care (including older people's care)

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. However, the service had a backlog of mortality cases that were awaiting review. This meant there were delays in identifying potential learning from deaths. When things went wrong, staff apologised and gave patients honest information and suitable support.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the trust policy.

Managers shared learning with their staff about serious incidents that happened elsewhere. Staff reported serious incidents clearly and in line with trust policy. They understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigations of incidents, both internal and external to the service. However, on occasions reviews of incidents reported by staff took too long which prevented prompt identification of root causes and potential learning opportunities. Staff reported that on occasion they would receive information the incident reported by them had been closed as 'historic' after being left on the incident reporting system for a prolonged time without any actions being identified and a full review being undertaken. The high volume of potentially reported incidents was identified as a risk to the service and included on the divisional risk register.

The service had a backlog of mortality cases that were awaiting structured judgement review, which was highlighted by the divisional mortality review committee that met quarterly. In August 2023 there were over 1000 cases that awaited closure of the structured judgement review process. This meant that the service potentially delayed opportunities to identify and implement learning from deaths.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

Is the service effective?

Good ↑

Our rating of effective went up. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Medical care (including older people's care)

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. There was finger food and snacks available all on wards.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. However, they have not always carried out a follow up assessment to monitor changes in patient's nutritional needs during their hospital stay.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Dietetic cover was available 9 am - 5 pm on weekdays and 8 am – 1 pm on Saturday and Sunday.

Pain relief

Staff monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate and when required gave additional pain relief to ease the pain. However, they did not always carry out an assessment to make the correct determine the most efficient treatment plan for patients presenting with pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. They monitored through internal audits if patients who reported pain had been appropriately responded to and suitable escalation occurred. Overall, the trust reported in its annual dementia statement that significantly fewer patients were assessed for pain within 24 hours of admission (51%) and in general during their stay at the hospital (72%) when compared with the national average (85% and 92% correspondingly). We did not have sufficiently detailed information to assess how individual medical wards performed in this area.

Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately. Staff could refer patients to, or obtain advice on pain management from, the local pain team which was available every day. They could also access the palliative care team which operated a 7-days service (9 am – 5 pm).

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Medical care (including older people's care)

The service participated in relevant national clinical audits. It included the Myocardial Ischaemia National Audit Project (MINAP), National Diabetes In-patient Audit-Harms, and the Sentinel Stroke National Audit Programme (SSNAP) amongst others.

Cancer Patient Experience Survey 2022 for the trust indicated that the trust had no scores above the expected range, which would indicate a more positive experience when compared with other trusts. There were nine questions where patients reported worse experiences (below the expected range) when compared with the national score. Those related to communication and overall information provision (6), overall care experience (2), and family and carers involvement. The hospital performed slightly worse in 27 questions when compared with 2021. For 16 questions the responses indicated a slightly better experience when compared with the previous year. In response, the hospital prepared an action plan that aimed to improve outcomes for patients.

Outcomes for patients were mostly positive, and consistent, and met expectations, such as national standards. Managers and staff used the results to improve patients' outcomes.

The service had set a target of 7% for emergency admission in less than 30 days from the initial discharge. They monitored the rate and compared it with the national average and local peer group. In the first half of 2023, they performed slightly worse than the set target with an average rate of 8%.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They used information from the audits to improve care and treatment.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time.

Managers shared and made sure staff understood information from the audits. Improvement, as directed by the audit outcomes, was checked and monitored.

Competent staff

The service made sure staff were competent for their roles. However, managers did not always appraise staff's work performance to provide support and development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work.

Only 70% of staff had been supported by their managers to develop thorough yearly, constructive appraisals of their work. This was below the trust target for appraisal (85%).

Managers supported nursing and clinical staff to develop thorough regular, constructive clinical supervision of their work.

The clinical educators supported the learning and development needs of staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. They also identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff we spoke with told us they felt they could contribute to decisions concerning care and treatment, and their knowledge and opinion was taken into consideration when decisions were made.

Patients had their care pathway reviewed by relevant consultants.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Patients had access to diagnostic services such as x-ray or computer tomography scans (CT) 24 hours a day. The trust organised the availability of key services in a way that did not hinder care delivery at night and during weekends.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. They encouraged patients to use the smoking cessation service and monitored the number of identified smokers referred to the service.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Medical care (including older people's care)

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked the capacity to make their own decisions. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient could make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available. They recorded consent in the patient's records.

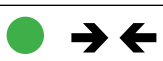
Although at the time of the inspection the trust could not provide information on training compliance in the Mental Capacity Act and Deprivation of Liberty Safeguards. After the inspection the trust told us over 88% of staff working within the division completed Mental Capacity Act and Deprivation of Liberty Safeguards training.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff could describe and know how to access policy and get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff implemented the Deprivation of Liberty Safeguards in line with approved documentation.

Is the service caring?

Good 

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

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patient feedback, as gathered by our expert by experience, was positive, indicating a high level of trust and satisfaction with the care provided. Patients said staff treated them well and with kindness. The friends and family test (FFT) results indicated an overall good response rate and positive experience reported at above 90% of patients at Topaz and Emerald wards, Acute Stroke Unit, and T5 ward (October 2023). The wards T7, T4, and Pearl ward noted positive

response rates below 70%. The division reviewed responses. Friends and family test allows patients to submit feedback to providers of NHS-funded care or treatment, using a simple question which asks how likely, on a scale ranging from extremely unlikely to extremely likely, they are to recommend the service to their friends and family if they needed similar care or treatment.

During our inspection, we observed the medical wards were calm, and staff interactions were supportive. Patients generally felt safe, and staff demonstrated a commitment to patient welfare.

Staff followed a policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients could be referred to psychology services, the psychiatric liaison team, and community services. Staff could also obtain advice from the mental health, safeguarding, or learning disability team to check if any specialist services could be accessed to support patients' or their relatives' wellbeing and meet their emotional needs.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions about their care.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service.

Medical care (including older people's care)

Is the service responsive?

Requires Improvement 

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

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

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population.

Staff knew about and understood the standards for mixed-sex accommodation and knew when to report a potential breach. The service was able to place patients on appropriate wards in line with guidance related to mixed-sex accommodation.

Facilities and premises were appropriate for the services being delivered.

The service had systems to help care for patients in need of additional support or specialist intervention.

The service relieved pressure on other departments when they could treat patients in a day.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However, not all staff received training which would help to raise awareness of how to respond to people's individual needs.

Staff supported patients living with dementia and learning disabilities by using '10 important things about me' documents and patient passports where available. However, only 38% of staff at the trust level received dementia awareness training. The trust did not provide information for specific medical wards. Staff told us they completed training on recognising and responding to patients with mental health needs, learning disabilities, deprivation of liberty safeguards, and autism.

Wards were designed to meet the needs of patients living with dementia. The hospital undertook a review of the environment and implemented changes when they identified needs that could benefit patients living with dementia.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The trust monitored how they performed against the learning disability improvement standards for NHS trusts. Staff were offered face-to-face training by a learning disability nurse and consultant learning disability physician. However, this training was not part of mandatory training, and the trust did not provide evidence to allow us to verify how many staff received this training. After the inspection the trust told us 72% of all staff completed e-learning module on learning disability and autism.

The service had information leaflets available in languages spoken by the patients and the local community.

Managers made sure staff, patients, loved ones, and carers could get help from interpreters or signers when needed. Staff booked face-to-face or telephone interpreting services and could do it within short notice. They told us they did not experience obstacles to effective communication with patients who did not use English as their first language,

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

Although people could access the service when they needed it and received the right care promptly, discharges were not always planned in advance. On occasions, staff moved patients between wards at night, which should be prevented.

Managers monitored and made sure patients could access services when needed and received treatment within agreed time limits and national targets. This included access to diagnostic services such as echocardiology, gastroscopy, colonoscopy, or other diagnostic procedures and tests.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment without delays.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service worked towards reducing the length of stay for medical patients with an overall target set at 9.4 days. Although the length of stay was reducing, they performed above the trust target in the first half of 2023 with an average stay of 12 days for inpatients. Staff supported patients when they were referred or transferred between services. Managers monitored patient transfers and followed national standards.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them. The hospital monitored patients with a length of stay above seven days and had processes to ensure any obstructions to potential patient's discharge were removed and social needs were addressed promptly if they identified blockers. However, discharge planning required improvement as the trust reported, in their annual dementia strategy, that only 27% of discharges were planned within 24 hours of admission. This was worse than the national average of 83.5%.

The number of super-stranded patients, who stayed as an inpatient on medical wards for longer than 21 days, was high and increased from 26.7% in July 2023 to 28.8% in September 2023.

On occasions, staff moved patients between wards at night. The majority of inappropriate nightly ward transfers were noted at short-stay wards such as Amber and the Acute Medical Unit (i.e. 59 transfers in June 2023). Managers monitored that patient moves between wards were kept to a minimum.

Managers worked to minimise the number of medical patients on non-medical wards. Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. The trust provided only a small sample of data to demonstrate if patients were bedded within appropriate speciality care settings. It indicated that on

occasions over 30% of ward patients were inappropriately placed on medical wards (7 Oct. – 5 Nov. 2023). Staff told us they did not experience major delays in patients from other specialities being assessed on medical wards. They felt medical patients placed outside of their medical speciality wards were also appropriately reviewed and their needs were met.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about the care received. The service experienced delays in reviewing complaints which meant investigating them and sharing lessons with staff was also delayed.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaints.

Managers shared feedback from complaints with staff and learning was used to improve the service. The main themes from complaints included poor communication by staff, missing information and miscommunication, and staff behaviours and attitudes. The division organised weekly complaints tracker meetings with handlers and divisional complaints reviews to ensure complaints were reviewed and responded to promptly. The division monitored if responses were provided promptly and within the timeline set by the organisational policies.

However, between April and September 2023, only 58 out of 102 complaints were investigated and completed within the prescribed timeframe. More recent complaint performance had been challenged and linked to operational pressures and industrial action. The trust had focused on the quality of the complaint response over the timeliness particularly for complex responses.

Staff could give examples of how they used patient feedback to improve daily practice

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced.

Medical care (including older people's care)

Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The medicine and urgent care division was led by the Divisional Director who was supported by an interim divisional director of operations and divisional director of nursing. There were leads for three clinical directorates: therapies, specialist medicine and urgent care, acute medicine, and care of the elderly. In addition, each speciality was allocated to one of 11 care groups, which had a clinical director, matron, and a service manager responsible for the day-to-day oversight.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

The vision and strategy were focused on the sustainability of services and aligned with local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had developed a strategy that was driven by performance analysis and local healthcare goals. It was divided into key metrics and project initiatives, the implementation of which was monitored at the divisional and trust level. The strategy focused on improving patient outcomes and patients' overall experience. Its initiatives were also aimed at improving work culture and increasing equality and diversity amongst the divisional workforce.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Most staff reported satisfaction working for the trust despite demanding conditions.

Divisional leads reviewed the NHS staff survey results, which were specific to their departments. They prepared an action plan, which aimed to enhance personal learning and development opportunities as well as reduce staff negative experiences and burnout and improve the health and safety culture. They reported on progress to the trust-wide culture improvement group.

The trust required staff to part take in conflict resolution and equality, diversity and human rights training. Staff achieved good participation rates in those trainings.

Governance

Leaders did not operate effective governance processes, as there were delays in identifying learning from deaths, incidents, and complaints.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Each speciality organised its speciality governance meetings that then informed divisional governance meetings and the trust-wide quality governance committee and the trust board.

The service did not always assess, monitor, and improve the quality and safety of the service provided. There was insufficient governance of the learning from deaths process with numerous structured judgment reviews being delayed at the speciality level. Occasionally, historic incidents raised by staff via the electronic reporting system were closed without being fully investigated. This meant the service experienced delays in identifying, or on occasions failed to identify, potential opportunities for making improvements. In addition, the service experienced delays in reviewing patients' complaints which meant that prompt investigation and learning from complaints could not be implemented swiftly. This also meant the service did not always assess, monitor, and mitigate the risks relating to the health, safety, and welfare of service users.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The service had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service monitored local risks which were recorded on the divisional risk register. Risks were approved by the executive team before they were added to the divisional risk register. The service identified risks that were jointly managed with other divisions, for example, risks related to the provision of care for children and young people with mental health needs. Some of the top risks for the division included gaps in the consultant's workforce, limited ability to provide non-invasive ventilation, fragile gastroenterology service, and a high volume of potentially unresolved incidents reported through the electronic incident reporting system. Staff rated risks appropriately, reviewed, monitored, and mitigated, they escalated appropriately through the trust governance structures.

The service used mobile inspection and auditing tools that aimed to educate and engage staff as they did their work and to make things better. The information collected by staff through local audits was compared with information collected via other sources and monitored for consistency. Where inaccuracies in data or non-submission were identified (i.e. ASU and T4 ward) the trust used 'Gemba walks' for monitoring potential areas of noncompliance and to verify potential causes for the discrepancy. Senior leaders used Gemba walks to identify ideas for improvement. The objective of a Gemba walk was to see what was happening at the ward level, to be in dialogue with front-line staff, and to assess processes from start to finish, to determine how successful it is.

Information Management

The service collected reliable data and analysed it.

Staff could find the data they needed, in easily accessible formats, to understand performance, and make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Engagement

Medical care (including older people's care)

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

The service collaborated with partner organisations to help improve services for patients.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Staff had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.