

North Middlesex University Hospital NHS Trust

North Middlesex University Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement	
Urgent and emergency services	Requires improvement	
Medical care (including older people's care)	Requires improvement	
Surgery	Good	
Critical care	Requires improvement	
Maternity and gynaecology	Requires improvement	
Services for children and young people	Requires improvement	
End of life care	Requires improvement	
Outpatients and diagnostic imaging	Requires improvement	

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

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

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

We last undertook a comprehensive inspection at the trust in June 2014 when we rated the trust as requires improvement overall.

Following concerns we undertook an unannounced inspection of two medical wards and the ED in April and May 2016. We rated the medical service as requires improvement overall and the ED as inadequate. We also issued a Warning Notice to the trust requiring them to make improvements to the ED by the end of August 2016.

Our key findings were as follows:

- The emergency department (ED) was not consistently achieving the 15 minutes performance standard for initial review of all patients arriving at ED.
- The ED was not meeting the target time to admit, transfer or discharge 95% of patients within 4 hours of their arrival in the ED.
- Substantial improvements have been made since the last inspection in May 2016. There was improved clinical governance and leadership at department level and oversight of this at trust level.
- Patient records had not been completed consistently, frequency of intervention was not always recorded and there was no evidence that the care of patients had been increased to reflect individual needs. Patient records were not always kept confidential or stored securely.
- Staffing levels on the wards did not always reflect the safer staffing acuity tool to determine safe staffing levels.
- We found that medicines were generally stored securely and appropriately, including those requiring refrigeration. Regular expiry date checks were in place and there were suitable arrangements for ensuring medicines were available out of hours.
- Most observed interactions between staff and patients were positive. Feedback from patients and relatives was generally good and they felt they were treated with courtesy, respect and compassion by staff. Staff maintained patients' privacy and dignity.
- The hospital consistently met the referral to treatment standard and performed better than an average English hospital.
- The departmental risk register did not fully indicate how risks were mitigated and who was responsible for implementing actions.
- Nurse staffing levels could be unpredictable and did not always meet national guidance. Safety checks on agency nurses were inconsistent and poorly managed.

Summary of findings

- Care and treatment was consultant led and medical staffing levels met national best practice guidance.
- The culture was not one of fairness, openness, transparency, honesty, challenge and candour. Staff reported bullying, harassment and discrimination amongst staff at all levels in the maternity unit. They said when they raised concerns they felt they were not treated with respect. The culture was defensive with poor collaboration between the staff working in different departments. High levels of conflict were reported to us.
- We were not assured that patients were being cared for in the right place at the right time, by adequately qualified staff. This meant that patients may not receive timely care in the appropriate part of the service and be cared for by competent staff which put them at risk.
- The majority of women and those close to them were positive about the care and treatment they had received. Women were able to telephone Maternity Direct in working hours and triage out of hours for emotional support.
- The service had a lack of ownership or oversight of children being cared for in other areas within the trust where the care environment was suboptimum and the service did not have oversight of young people over the age of 16 years who were cared for in adult clinical areas of the trust.
- There was poor oversight of patients with learning disabilities who were not identified on admission.
- The service had effective systems to identify children who might deteriorate whilst receiving care and used the recently introduced Royal College of Paediatrics and Child health SAFE Programme based on work undertaken at the Cincinnati Children's Hospital in the USA.
- NICE guidance for EoLC staffing showed a seven day service should be provided for EoLC, however this had not occurred. A business case was awaiting review.
- There was no non-executive director on the board responsible for EoLC.
- A minimum of 50% of registered nurses on every ward had received some form of training from the SPCT. This was the trust target.
- Overall, patients were treated with dignity, respect and care by staff. Although, some patients told us staff were rude and uncaring. Most patients spoke positively about staff but did not always feel well informed about their care and the procedures being undertaken.
- The proportion of people waiting less than 62 days from urgent GP referral to first definitive treatment was below the national average and had deteriorated in the first quarter of 2016/17.
- The percentage of patients seen within two weeks for all cancers was higher than the national average. Also, the cancer waiting times for people waiting less than 31 days from diagnosis to first definitive treatment were higher than the national average and above the standard target of 96%.

We saw several areas of outstanding practice including:

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

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

Importantly, the trust must:

Summary of findings

Urgent and Emergency Services

- The trust must ensure learning from incidents is more robust and shared with all staff.
- The trust must ensure that all medicines and instruments associated with a resuscitation are disposed of safely after use.
- The trust must ensure the renewal of advanced paediatric life support (APLS) certificates of those doctors and consultants whose certificates had expired
- The trust must improve mandatory training levels for medical and nursing staff.
- The trust must improve safeguarding adults level 2 training for medical and nursing staff.
- The trust must improve safeguarding children level 2 training for medical and nursing staff.
- The trust must improve hand hygiene levels especially amongst medical staff.
- The trust must ensure medical and nursing staff are fully trained and able to identify and support the needs of patients living with dementia.
- The trust must ensure medical and nursing staff are fully trained and able to identify and support the needs of patients with learning disabilities.
- The trust must improve appraisal rates of nurses.

Surgery

- The trust must ensure all actions in response to the never event are fully implemented.
- The trust must review and identify causes for the higher than the national average mortality rate as suggested by the bowel cancer and the national hip fracture audit data.

Outpatients and Diagnostic Imaging

- The trust must ensure there are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up.
- The trust must ensure there are appropriate processes and monitoring arrangements in place to improve the 32 and 61 day cancer targets in line with national targets.
- The trust must ensure there is improved access for beds to clinical areas in diagnostic imaging.

Maternity and gynaecology

- The trust must carry out an audit of the stillbirth rate for the period January to December 2016 and develop an action plan to address themes.
- The trust must provide one to one care in labour to all women.
- The trust must replace all damaged equipment in EGU and triage.
- The trust must monitor and report in VTE compliance.
- The trust must monitor the temperature of medicines storage.
- The trust must review waiting times in triage and develop an action plan to address themes.
- The trust must ensure mandatory training and multidisciplinary intrapartum care training targets are met.
- The trust must display cleaning schedules or checklists all clinical areas.
- The trust must ensure staff in maternity observe the 'bare below the elbows' policy.
- The trust must ensure patients have a named midwife.

End of Life Care

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

In addition the trust should:

Summary of findings

Urgent and Emergency services

- The trust should continue to make improvements to 15 minutes to triage time.
- The trust should maintain consistent achievement of 80% target of 15 minutes to ECG.
- The trust should ensure there is a supply of paediatric emergency medicines in the paediatric high dependency room.
- The trust should develop statement of purpose for escalation when a patient with a mental health illness absconds from the department.
- The trust should record children's weights in paediatric patients' records.
- The trust should rectify IT issues in paediatric ED to ensure all PEWS scores are recorded.
- The trust should develop a chest pain pathway.
- The trust should develop a frailty pathway.
- The trust should ensure there is a sufficient number of wheelchairs available to facilitate timely ambulance handover of patients.
- The trust should improve patient comfort with the availability of snacks for patients 24/7.
- The trust should improve quality of major incident awareness amongst all staff.

Surgery

- The trust should ensure departmental risk register indicates how risks are to be mitigated and who is responsible for implementing actions.
- The trust should ensure staff improve recording of pressure ulcers, raise incidents and safeguarding alerts when appropriate.
- The trust should ensure reporting of actions from mortality and morbidity meetings is formalised and ensure learning and actions are shared across the trust.
- The trust should ensure individual venous thromboembolism risk assessments (VTE) are fully completed for all patients.
- The trust should improve average waiting time for a patient discharge prescription.
- The trust should improve utilisation rate for operating theatres and its efficiency.
- The trust should review if all qualifying patients are screened for dementia.

Critical Care

- The trust should ensure all staff have adequate knowledge of safeguarding policies and processes.
- The trust should ensure nurse to patient ratios are managed in relation to the individual needs of patients, including whether they are bedbound and/or cared for in a side room and in relation to the guidance of the ICS core standards for intensive care.
- The trust should ensure staff have appropriate support and supervision to meet their needs in relation to professional and contractual activity.
- The trust should ensure all staff who care for patients have the appropriate personal skills to demonstrate understanding and kindness.
- The trust should ensure learning from infection prevention and control audits are implemented by all staff.

Outpatients and Diagnostic Imaging

- The trust should ensure its target for compliance with mandatory training is met by staff.
- The trust should ensure there is access to seven day week working for radiology services.
- The trust should ensure staffing is improved in radiology for sonographers.

Children and Young people services

Summary of findings

- The trust should ensure that all children and young people up to their 19th birthday wherever they are cared for in the hospital should come under the governance of children's services which will ensure that they have oversight of all children and young people wherever they are treated in the hospital.
- The trust should improve drug refrigerator temperature monitoring and replace faulty fridges with new equipment where required in order to ensure medication is safely stored.
- The trust should gather feedback from children and young people who use their services and use this information to inform and improve service planning.
- The trust should ensure that play provision for children in hospital should be enhanced to meet national standards.

Maternity and gynaecology

- The trust should develop a clear vision and strategy for the maternity and gynaecology service.
- The trust should review the group sessions for the first antenatal appointment.
- The trust should carry out a review of culture within maternity and use tools such as 'walk in my shoes'.

Medical care (including older people's care)

- The trust should ensure that staff report incidents through the online reporting system and there is a formal process for feeding back to staff.
- The trust should ensure Mortality and Morbidity review meetings are used to identify action points or lessons learnt and that these are recorded.
- The trust should ensure patient records are completed consistently and patient records are always kept confidential and stored securely.
- The trust should ensure staff wash their hands between patients and wear appropriate PPE.
- The trust should ensure that staffing levels on the wards reflect the safer staffing acuity tool to determine safe staffing levels.
- The trust should ensure nursing staff know how to use the settings for the pressure relieving mattress.
- The trust should ensure compliance with mandatory training meets the trusts target for infection prevention and control training, health safety and welfare, information governance, safeguarding, safeguarding children and fire safety.
- The trust should ensure that feeder cups and meals are left within easy reach of patients.
- The trust should ensure that staff are trained in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards and that staff seek patients' consent before care or treatment is given.
- The trust should ensure that activities, such as cards, games or puzzles, are provided on the care of the elderly wards.
- The trust should ensure that staff have feedback about complaints or learning from them.

End of Life Care

- The trust should ensure they meet the minimum requirements for consultant staffing as set out within the Royal College of Physicians guidelines.
- The trust should provide a seven day face to face service as set out within NICE guidance for EoLC.
- The trust should carry out mental capacity assessments on all patients deemed to lack capacity prior to completing a DNACPR form in line with trust policy.
- The trust should keep the risk register up to date at all times.
- The trust should ensure patient care is delivered in line with the patients' care plans at all times.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement



Rating

Why have we given this rating?

We rated this service as requires improvement because:

- Staffing remained fragile as it relied on a large amount of agency doctors to fill shifts. At the time of our inspection there were a number of temporary doctors working in the department including two doctors who were on short term secondments from other trusts.
- The emergency department (ED) was not consistently achieving the 15 minutes performance standard for initial review of all patients arriving at ED.
- The ED was not meeting the target time to admit, transfer or discharge 95% of patients within 4 hours of their arrival in the ED.
- Staff recorded incidents but were unclear about how learning was shared from these incidents.
- Staff did not have sufficient understanding of the needs of patients living with dementia and those with a learning disability.

However:

- Substantial improvements have been made since the last inspection in May 2016.
- There was clear nursing and medical leadership visibility within the department, and staff felt able to highlight issues to them. The governance arrangements were clear to staff we spoke with.
- There was improved clinical governance and leadership at department level and oversight of this at trust level.
- There was an effective nurse led clinical assessment and ambulance triage process in place.
- There was an increase in consultant and middle grade doctors and an increase in night time medical cover, since our last inspection.
- Patient records were easily accessible.
- Patients told us that staff were compassionate and respected their dignity and privacy.

Summary of findings

Medical care (including older people's care)

Requires improvement



We rated this service as requires improvement because:

- Staff understood how to report incidents, however these were not always reported through the online reporting system and there appeared to be no formal process for feeding back to staff. Mortality and Morbidity review meetings did not always identify action points or lessons learnt.
- Patient records had not been completed consistently, frequency of intervention was not always recorded and there was no evidence that the care of patients had been increased to reflect individual needs. Patient records were not always kept confidential or stored securely.
- There were adequate supplies of personal protective equipment (PPE); however staff did not always wash their hands between patients and wear gloves or aprons.
- Staffing levels on the wards did not always reflect the safer staffing acuity tool to determine safe staffing levels.
- Nursing staff we spoke with did not know about the settings for the pressure relieving mattress. They were unable to tell us how they set them up and staff showed no understanding of what the warning lights meant.
- Compliance with mandatory training was below the trusts target for infection prevention and control training, health safety and welfare, information governance, safeguarding, safeguarding children and fire safety.
- The trust participated in national audits which showed the trust's performance was below the national targets and the hospital was achieving variable outcomes for patients compared with the national average. These included the Sentinel Stroke National Audit Programme (SSNAP), the Myocardial Ischemia National Audit Project (MINAP), and the National Diabetes Inpatient Audit (NaDIA).
- At weekends a consultant was only available on site from 9am to 8pm to see new admissions and seriously ill patients. However, outside of these hours an on-call consultant provided cover.
- Food and fluid charts were in place for patients who required monitoring, however we found

Summary of findings

that staff had not always completed these charts appropriately and accurately which could affect patients' care and treatment. Feeder cups and meals were not always left within easy reach of patients.

- Staff knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards was variable. Mental Capacity Act 2005 (MCA) and DoLS training was not part of the trust's mandatory and statutory training programme. We saw that patients' Deprivation of Liberties Safeguards (DoLS) applications had expired and patients were still subject to restraint. Staff did not always ask patients permission before care or treatment was given.
- We spoke with 39 patients and their relatives about their experience. The feedback from patients indicated staff were not providing good care and treatment.
- Patients were not treated with dignity and respect; we observed staff speaking unkindly and in a patronising way to patients.
- Nursing staff and doctors did not always introduce themselves or tell the patients what they were doing.
- Feedback from relatives was mixed.
- We found no evidence of activities such as cards, games or puzzles on the care of the elderly wards.
- We looked at 15 sets of patient records. We found that nursing assessments and care plans were mostly incomplete. This meant that patients' care needs were not all identified and that patients could be receiving care that was not appropriate to their needs.
- The percentage of patients that started consultant led treatment within 18 weeks was consistently lower than the England average of 90%.
- The trust reported the total number of bed moves across the medical wards at night between the hours of 10pm and 6am was 315. The largest number of moves involved patients in general medicine 54.6% (172) and care of the elderly 16.5% (51).

Summary of findings

- The average length of stay was longer (6.1 days) than the England average (3.9 days) for elective care between March 2015 and February 2016.
- Staff we spoke with told us that they rarely had feedback about complaints or learning from them.
- The trust had a dementia strategy in place; however, of the 23 action points seven had been completed and 16 remained outstanding. The trust had not prioritised the dementia strategy; however since the arrival of the new executive team this was beginning to change.
- Complaints were discussed at monthly clinical governance meetings. We saw that complaints were monitored and outcomes recorded with details of action points and learning identified. However, Monthly ward meetings did not disseminate learning from incidents or complaints.
- The trust had a zero tolerance policy for staff speaking in languages other than English. We observed this on some wards and saw no action was taken to address this.
- Staff we spoke with that worked on Pymmes Zero ward told us that they had not been involved in any of the refurbishment plans to make the ward dementia friendly. However, we were told by the trust that the ward manager and matron for Pymmes Zero ward had been involved in planning the refurbishment.

However:

- Most staff were aware of their responsibilities under duty of candour.
- We found that medicines were generally stored securely and appropriately, including those requiring refrigeration. Regular expiry date checks were in place and there were suitable arrangements for ensuring medicines were available out of hours.
- Staff had access to the trust's safeguarding policy via the trust intranet and knew how to access the safeguarding team for advice and guidance when required.
- Multidisciplinary (MDT) working was evident on medical wards. There was evidence of an MDT

Summary of findings

approach to discharge planning. Patients had access to the full range of allied health professionals such as speech and language therapists, dietitians, tissue viability and diabetic nurses.

- Endoscopy, diagnostic services including imaging, physiotherapists and occupational therapists and pharmacy services and laboratory were available seven days per week.
- Most staff had received an appraisal. The trust reported 84.5% of nursing staff within the medical services had received an appraisal. This was above the trust target of 80%.
- Patients we spoke with told us they felt involved in their care and understood their treatment and care plans.
- The trust used the Friends and Family Test (FFT) to gather patients' views on whether they would recommend the service to family and friends. Overall, these showed satisfaction with the service, with the medical wards ranging from 58% to 100% during the period.
- The hospital admitted patients for the day so that they could undergo tests. Relatives either brought patients in or the hospital arranged for patients to come via the patient transport service.
- Staff in endoscopy had identified Turkish, French and Polish as the most commonly spoken languages other than English amongst their patients. To meet their needs information leaflets about preparing for endoscopic procedures were available in these languages.
- Staff told us that some members of the new executive team were visible on the wards, some staff we spoke with felt more confident that things were changing.
- The leadership team responsible for the endoscopy unit had included staff at all levels in plans for the temporary move of the unit, including how the unit would operate on their return after the refurbishment.

Surgery

Good



We rated this service as good because:

- All observed interactions between staff and patients were positive. Feedback from patients

Summary of findings

and relatives was good and they felt they were treated with courtesy, respect and compassion by staff. Staff maintained patients' privacy and dignity.

- Patients' nutritional needs were assessed and catered for appropriately.
- Patients were supported with pain management and said someone regularly checked them to ensure they were comfortable and they were offered pain relief when needed.
- Patients had access to an immediately available, fully staffed emergency theatre and a consultant 24 hours a day.
- All staff we spoke with demonstrated a good awareness of policies and how to access them. Local policies and guidelines were based on appropriate national guidelines
- The hospital consistently met the referral to treatment standard and performed better than an average English hospital.
- The hospital participated in national audits such as joint registry, national hip fracture, and the national emergency laparotomy audit. The hip fracture audit indicated the hospital performed better than the England average for patients undergoing surgery within 36 hours of admission. The indicator related to patients admitted to an orthopaedic ward within four hours was significantly better than the average for London hospitals. The hospital performed better than the England averages for two of the three knee-replacement indicators.
- Staff had access to data which supported service quality monitoring and they were able to use it to inform service delivery.
- The rate of cancelled operations was consistently lower than the England average and if cancellations occurred, all patients were treated within the subsequent 28 days.
- There were no delays in patient transfers from recovery to the ward. Most surgical patients were treated on surgical wards.
- The hospital had developed innovative pathways where surgical patients could avoid re-admission by involving the 'hospital at home' team and surgical assessment unit in their care.

Summary of findings

- There were daily preoperative assessment clinics with a walk-in service available to all patients.
- We observed good multidisciplinary team working across the department.
- There was effective and well embedded clinical governance structure.
- The local leadership was well established and could provide sufficient oversight of activity within the division. The division had a local annual strategy which reflected departmental needs.
- Staff felt positive about the changes in the trust's senior management team and said communication and organisational culture was improving. They felt respected and valued by the managers and matrons.
- There were sufficient staffing, including doctors, nurses and theatre staff to meet patients' needs.
- We observed that there were effective infection prevention and control measures in place. We saw staff practice appropriate hand hygiene. The hospital was clean and there was a low rate of surgical site infection. There were no hospital acquired MRSA infections reported for the surgery division in 2015/2016.
- In elective and non-elective treatment cases, the observed emergency readmissions rate was within expectations.
- Emergency medicines and equipment was available to staff to allow prompt response in emergency.

However:

- The departmental risk register did not fully indicate how risks were mitigated and who was responsible for implementing actions.
- Actions in response to the never event were not fully implemented.
- Patients with pressure ulcers had not had the incident electronically logged despite staff's awareness of the requirement of recording pressure ulcers. They did not routinely raise a safeguarding alert in cases where a patient acquired a severe avoidable pressure ulcer during their stay at the hospital.

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- The hospital did not comply with the national guidance which recommends that the ratio of recovery beds to operating theatres should not be less than two.
- Bowel cancer patients' related data suggested the risk-adjusted two-year post-operative mortality rate was much higher than the national average. The clinical audit related to patients admitted with hip fracture in 2015 indicated that risk-adjusted 30-day mortality rate, although significantly better than during the previous year, was worse than expected.
- None of the nursing staff working on surgical assessment unit completed advanced life support training. The Resuscitation Council recommends that all staff working in acute areas complete advanced life support training.
- Reporting of actions from mortality and morbidity meetings was not formalised to allow learning and actions to be captured and shared across the trust.
- Individual venous thromboembolism risk assessments (VTE) were not fully completed.
- The pharmacy team did not meet their 2 hours target for average waiting time for a patient discharge prescription.
- Average length of stay at the hospital was longer than the England average for elective trauma and orthopaedics, general surgery and urology patients. It was also longer than the England average for non-elective urology.
- The utilisation rate for operating theatres was low and the hospital needed to improve efficiency within theatres.

Critical care

Requires improvement



We rated this service as requires improvement because:

- There was inconsistent learning and evidence of change management from clinical incidents. There was also limited evidence of learning or improvement following audits, complaints, patient feedback and morbidity and mortality meetings.
- We found good infection prevention and control audit practices were in place but staff practice during our inspection did not always reflect this.

Summary of findings

- Nurse staffing levels could be unpredictable and did not always meet national guidance. Safety checks on agency nurses were inconsistent and poorly managed.
- Levels of mandatory training did not meet the trust's minimum target.
- Multidisciplinary team working was of a high standard but low levels of staffing meant the unit could not meet the requirements of the National Institute of Health and Care Excellence (NICE) in relation to the rehabilitation of patients.
- Patients and relatives had provided consistent feedback on variable communication and involvement by clinical staff. This included a lack of consistency between nurses and occasions where they felt staff were unfriendly and unapproachable.
- There were limited resources on the unit for patients with dementia or learning disability. Staff knowledge was variable, including amongst nurses in relation to consent and mental capacity.
- Out of hours discharges were significantly higher than the national average and clinicians actively tried to avoid discharging patients at a weekend due to short staffing on inpatient wards.
- Staff morale was variable and we received a number of complaints about bullying and victimisation.
- Staff morale was variable and we received a number of complaints about bullying and victimisation. We saw little evidence the senior team had taken appropriate action to address these concerns and staff we spoke with told us they lacked confidence in the trust's human resources department.

However:

- Care and treatment was consultant led and medical staffing levels met national best practice guidance.
- Medicines management was of a high standard, with consistent input and safety oversight from a dedicated pharmacist.

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- Staff used the national guidance of a number of organisations to benchmark their practice and to ensure care and treatment was safe.
- A new practice development nurse was in post, which would significantly improve oversight of staff training and competency checks.
- New training had been provided to staff in the care of patients with dementia and in communication skills. Both programmes were implemented in response to patient and relative feedback and aimed to improve quality of service.
- Rates of delayed discharges were significantly lower than the national average.
- The senior team had a clear vision and strategy for the unit and its staff team for 2016/17, which addressed staff turnover and skill mix.

Maternity and gynaecology

Requires improvement



We rated this service as requires improvement because:

- We were not assured that the culture of the maternity services, staffing and capacity protected safe patient care.
- Systems, processes and standard operating procedures in maternity were not always reliable or appropriate to keep people safe.
- Staff were not confident their concerns were listened to or acted upon.
- We were not assured that staff were recording incidents correctly or that actions plans were put in place and monitored.
- Insufficient staffing levels meant midwives did not always provide one to one during labour. Only 80% of patients received one to one care in labour which was not in line with national guidance.
- We were not assured that patients attending triage were attended to in a timely manner.
- We were not assured that patients were being cared for in the right place at the right time, by

Summary of findings

adequately qualified staff. This meant that patients may not receive timely care in the appropriate part of the service and be cared for by competent staff which put them at risk.

- The overall compliance with mandatory training for nurses and midwives in CBU 5 was 82.5% compared to the trust target compliance of 90%.
- 62% of midwives and 53% of obstetricians had attended multidisciplinary intrapartum care training against a trust target of 90%.
- The trust was not meeting National Screening Committee targets for antenatal and newborn screening.
- National specifications for the prevention and control of infection were not always adhered to. There were no cleaning schedules or checklists available in any of the inpatient or outpatient areas we visited.
- There was no documentary evidence that any patients had a risk assessment to determine their individual risk of developing blood clots, or that this was being monitored.
- Ambient temperatures of areas where medicines were stored were not monitored which meant that staff could not be sure that the manufacturers' instructions for storage were followed.
- We saw care and observation of a person receiving a blood transfusion in the gynaecology inpatient service was not in accordance with national or local guidance.
- Staff in maternity did not always observe the 'bare below the elbows' policy.
- The trust was offering group sessions for the first antenatal appointment known as the 'booking' appointment.
- Patients did not have a named midwife.
- We were not assured that the trust was implementing and reviewing audit recommendations.

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- We were not assured that the trust was effectively monitoring the number of stillbirths. There was no action plan in place to address the stillbirth rate. The stillbirth rate was 6.7 per 1,000 births in 2015 which was greater than the national average of 4.7 per 1,000. The trust was not using customised growth charts to monitor fetal growth. We were not assured the service was monitoring and evaluating stillbirth rates to make improvements.
- Multidisciplinary team (MDT) working was not always effective in the maternity service.
- Patients' privacy and dignity were not always protected.
- Staff did not always address patients in an appropriate manner.
- Patients, partners and relatives did not always feel involved in their care.
- There were long waiting times in triage. We saw that a patient waited for 50 minutes before being seen. Staff told us that patients can be in triage for up to seven hours in labour due to the lack of capacity or the willingness of the midwives on labour ward to accept women.
- Staff told us patients using the gynaecology service were generally seen promptly for treatment, however, this was not formally monitored.
- The leadership, governance and culture did not always support the delivery of high quality person centred care. Leaders did not have the necessary experience, knowledge, capacity, or capability to lead effectively.
- There was no clear vision and strategy for the maternity and gynaecology service. Staff could not tell us of future plans for the maternity service; however outpatient gynaecology staff described the relocation of their services to more suitable accommodation.
- The culture was not one of fairness, openness, transparency, honesty, challenge and candour. Staff reported bullying, harassment and

Summary of findings

discrimination amongst staff at all levels in the maternity unit. They said when they raised concerns they felt they were not treated with respect. The culture was defensive with poor collaboration between the staff working in different departments. High levels of conflict were reported to us.

However:

- Staff were trained to the appropriate level in safeguarding adults and children and were aware of their responsibilities to ensure patients and children were protected from abuse and avoidable harm.
- In gynaecology, there were systems in place to recognise and manage deteriorating patients. Appropriate triggers were in place to ensure patients who had deteriorated were treated according to their clinical needs.
- During the reporting period there were no reported incidents of hospital acquired infections.
- All clinical staff had access to a microbiologist and specialist infection prevention and control nurse when required.
- Staff were observed in the correct use of personal protective equipment.
- Staff had access to and used evidence-based guidelines to support the delivery of effective treatment and care.
- Termination of pregnancy for fetal abnormality was offered in line with legal requirements and professional guidance.
- Women we spoke with felt that their pain had been well managed. Epidurals were available over a 24-hour period.
- Access to medical support was available seven days a week. Community midwives were on call 24 hours a day to facilitate the home-birth service.

Summary of findings

- The majority of women and those close to them were positive about the care and treatment they had received. Women were able to telephone Maternity Direct in working hours and triage out of hours for emotional support.
- A bereavement midwife saw all patients who experienced pregnancy loss, including visits at home if required.
- The trust had a chaplaincy team who were available to provide pastoral and religious support to patients and their families.
- The maternity service was flexible and provided choice and continuity of care. Patients' individual needs and preferences were considered when planning and delivering services.
- The individual care needs of women at each stage of their pregnancy were acknowledged and acted on as far as possible. There were arrangements in place to support patients with particular needs.
- Complaints about maternity and gynaecology services were initially managed and resolved locally. If complaints could not be resolved at ward level, they were investigated and responded to appropriately.
- Guidelines we reviewed were in date, reflected current NICE guidance and best practice, and included evidence of learning from SI reviews.
- There were good clinical working relationships between the medical staff.
- The trust participated in the North Central London Maternity Services Liaison Committee (MSLC), a specialist user involvement forum which brought together users and health professionals to develop women-centred maternity services.

Services for children and young people

Requires improvement



We rated this service as requires improvement because:

- The service had a lack of ownership or oversight of children being cared for in other areas within

Summary of findings

the trust where the care environment was suboptimum and the service did not have oversight of young people over the age of 16 years who were cared for in adult clinical areas of the trust.

- Although some young people in transition had been consulted on their transition to adult services, audits to fully capture the voices of children and young people had not been undertaken.
- There were some ongoing issues with staffing levels and only 56% of the nurses in the neonatal unit were qualified in that speciality.
- There was poor oversight of patients with learning disabilities who were not identified on admission.

However:

- This service provided generally good care to children and babies within good standards of accommodation where the environment in which children were cared for was reflective of their needs.
- The service had effective systems to identify children who might deteriorate whilst receiving care and used the recently introduced Royal College of Paediatrics and Child health SAFE Programme based on work undertaken at the Cincinnati Children's Hospital in the USA.
- There was a good level of safeguarding awareness among staff we spoke with.
- We saw that there was excellent multidisciplinary team (MDT) working and clinical teams worked collaboratively to enhance the provision of care to children. Parents told us that they were fully involved in the care delivered to their children and that health care professionals kept them informed at all times as to the progress of their individual children.

End of life care

Requires improvement



We rated this service as requires improvement because:

Summary of findings

- The Royal College of Physicians states there should be a minimum of 1 WTE palliative care consultant per 250 beds. This means the trust was not meeting the minimum requirement set out as it only has a total WTE of 1 for 384 acute adult inpatient beds.
- NICE guidance for EoLC staffing stated a seven day service should be provided for EoLC, however this had not occurred. A business case was awaiting review.
- Complaints regarding the palliative or end of life care service were not being coded correctly, therefore there was a lack of awareness of concerns or complaints.
- Incidents were recorded on the electronic reporting system used by the hospital although the same type of incidents reoccurred on a number of occasions. This suggests no learning was taken from the incident to prevent it reoccurring.
- There was no clear EoLC strategy. The specialist palliative care team (SPCT) were aware of improvements required within their service however they felt these were due to trust financial constraints.
- There was inconsistency found in DNACPR audits and no clear action plan to address the issues found.
- Bereavement surveys were not carried out, therefore the trust could not monitor or benchmark its performance against other providers. The trust was now collaborating with other partners to introduce a London wide questionnaire, however this was still in the initial stages.
- Mental capacity forms were not always completed for patients that lacked capacity and had a DNACPR order completed which was against trust policy.
- Advanced care planning was not always taking place for patients and this was recognised by the trust as an area for improvement.
- The risk register had only recorded one risk, although there were other concerns identified during our inspection. The risk register was not kept up to date.

Summary of findings

- We observed poor patient care and felt this was improved but not to a standard that was fully appropriate.

However:

- Pain was managed appropriately and in a timely fashion. Records showed patients were monitored for signs of deterioration by completion of the national early warning score (NEWS) tool.
- The mortuary had clear records and traceability for deceased patients.
- Bereavement officers were compassionate towards bereaved relatives and were able to give good advice and guidance.
- A minimum of 50% of registered nurses on every ward had received some form of training from the SPCT. This was the trust target.

Outpatients and diagnostic imaging

Requires improvement



We rated this service as requires improvement because:

- Staff reported patient safety incidents and there was some evidence of learning from incidents and patient complaints. However, feedback from staff did not demonstrate consistency in all areas. There was a process in place to report ionising radiation medical exposure (IR(ME)R) incidents and the correct procedures were followed. However, the governance and monitoring arrangements need to be strengthened as these had been lacking in past months.
- Overall, patients were treated with dignity, respect and care by staff. Although, some patients told us staff were rude and uncaring. Most patients spoke positively about staff but did not always feel well informed about their care and the procedures being undertaken.
- The services we inspected were generally clean but there were some areas that needed further attention.
- There was a shortage of key staff, in particular band 5 and 6 radiographers, ultrasonographers, histopathologists and outpatient nurses. Staff morale was mixed but we observed a good team spirit and optimism for the future.

Summary of findings

- There were policies and procedures in place in relation to consent and the Deprivation of Liberty Safeguards. However, the staff we spoke with had very limited understanding of these issues.
- All staff we spoke with understood how to obtain informed consent. Safety measures were in place for consenting to diagnostic imaging procedures.
- Records were not always available for clinics although improvements had been made in recent months.
- Staff were aware of their responsibilities within adult and children safeguarding practices and good support was available within the hospital.
- There was limited support for patients with a learning disability or living with dementia.
- The diagnostic imaging department had produced a local workforce plan so that projected capacity would meet demand from 2015-2020. However, there was no capital improvement plan for ageing equipment.
- The proportion of people waiting less than 62 days from urgent GP referral to first definitive treatment was below the national average and had deteriorated in the first quarter of 2016/17.

However:

- The percentage of patients seen within two weeks for all cancers was higher than the national average. Also, the cancer waiting times for people waiting less than 31 days from diagnosis to first definitive treatment were higher than the national average and above the standard target of 96%.
- Nursing staff vacancy levels were low. A few vacancies were currently being recruited to. The diagnostic imaging vacancies were higher, particularly ultrasonographers. However, there was an ongoing recruitment and retention plan in place.
- There was evidence of service planning to meet patient need such as the emergency eye service offered Monday to Friday 8.30am to 4pm for patients with sight threatening eye conditions, requiring urgent specialist ophthalmic

Summary of findings

treatment. There were extended days for diagnostic imaging appointments. National waiting times were met for outpatient appointments and access to diagnostic imaging.

- Staff had good access to evidence based protocols and pathways. There was limited audit of patient waiting times for clinics but patients received good communication and support during their time in the outpatients and diagnostics departments.
 - Staff were aware of the complaints policy and told us how most complaints and concerns were resolved locally.
 - Governance processes were in a process of change across outpatients and diagnostics and the new structure was not yet embedded. Clinical governance knowledge was limited within certain divisions of outpatients. However, good progress was evident for improving services for patients.
 - We found evidence of strong local leadership and a positive culture of support, teamwork and focus on patient care.
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North Middlesex University Hospital

Detailed findings

Services we looked at

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

Detailed findings

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Background to North Middlesex University Hospital

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

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

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

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

Our inspection team

Our inspection team was led by:

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

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

The trust was visited by a team of CQC inspectors, assistant inspectors, analysts and a variety of clinical and

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

Detailed findings

How we carried out this inspection

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

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

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

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology

- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These organisations included the clinical commissioning groups, Monitor, Health Education England, General Medical Council, Nursing and Midwifery Council, Royal College of Nursing, NHS Litigation Authority and the local Healthwatch.

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

Facts and data about North Middlesex University Hospital

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

Key Figures

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

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

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

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

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

Financial data 2015/16

Revenue: £250 million

Full Cost: £258 million

Deficit: £8 million

Activity type 2015/16

There were 56,880 recorded inpatient admissions

There were 348,276 recorded outpatient attendances

There were 171,840 recorded attendances through the Emergency Department

Safe?

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

Detailed findings

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

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

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

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

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

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

Effective?

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

Caring?

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

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

In the Cancer Patient Experience Survey 2015, the trust scored "lower than expected" for 30 of the 50 indicators. These included all the indicators relating to diagnostic

tests, "finding out what was wrong with you" more generally and home care and support. They also included all but one of the questions relating to 'deciding on the best course of treatment'. There were no indicators where the trust performed better than expected.

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

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

Responsive?

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

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

Well Led?

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

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

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

Detailed findings

recommending the trust as a place to work or receive treatment and the percentage of staff experiencing discrimination at work in the last 12 months. The trust was within expectations for the remaining 20 questions.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Medical care	Requires improvement					
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Requires improvement	Requires improvement	Inadequate	Requires improvement
Services for children and young people	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Requires improvement					
Outpatients and diagnostic imaging	Requires improvement	Not rated	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement					

Urgent and emergency services

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

Information about the service

The emergency department (ED) at the North Middlesex University Hospital is one of the busiest in London, and had 171,840 attendances in 2015/16. The service also includes an urgent care centre (UCC), which operates within the ED. This provides treatment of minor illnesses, injuries and non-life-threatening conditions which require urgent or immediate attention. The unit is led by GPs and is open every day from 9am to 10pm.

There is a dedicated 24/7 paediatric emergency service. Children are triaged in ED and seen either in the paediatric emergency department or by the urgent care centre (UCC). All children are cared for by paediatric nurses.

We carried out an inspection in May 2016 and rated the department as inadequate. We issued a warning notice in which we requested the hospital to make significant improvements in identified areas by 26 August 2016.

We inspected resuscitation (resus), area 1 (minors and majors overflow), area 2 (majors, more seriously ill patients), and the urgent care centre (UCC). During our inspection, we spoke with 36 relatives and patients. We examined 26 sets of adult patient records and 10 paediatric patient records.

Summary of findings

We rated this service as requires improvement because:

- Staffing remained fragile as it relied on a large amount of agency doctors to fill shifts. At the time of our inspection there were a number of temporary doctors working in the department including two doctors who were on short term secondments from other trusts.
- The emergency department (ED) was not consistently achieving the 15 minutes performance standard for initial review of all patients arriving at ED.
- The ED was not meeting the target time to admit, transfer or discharge 95% of patients within 4 hours of their arrival in the ED.
- Staff recorded incidents but were unclear about how learning was shared from these incidents.
- Staff did not have sufficient understanding of the needs of patients living with dementia and those with a learning disability.

However:

- Substantial improvements have been made since the last inspection in May 2016.
- There was clear nursing and medical leadership visibility within the department, and staff felt able to highlight issues to them. The governance arrangements were clear to staff we spoke with.

Urgent and emergency services

- There was improved clinical governance and leadership at department level and oversight of this at trust level.
- There was an effective nurse led clinical assessment and ambulance triage process in place.
- There was an increase in consultant and middle grade doctors and an increase in night time medical cover, since our last inspection.
- Patient records were easily accessible.
- Patients told us that staff were compassionate and respected their dignity and privacy.

Are urgent and emergency services safe?

Requires improvement



We rated safe as requires improvement because:

- There was high usage of agency doctors and nurses.
- The ED was not meeting the ambulance handover target time of 15 minutes.
- Staff did not feel there was a consistent approach to the sharing of learning from incidents both in the emergency department (ED) and from other departments.
- Concerns were identified by the NHS England specialised commissioning body about the use of root cause analysis methodology and the variable quality of investigation reports.
- Hand hygiene audit compliance levels were below target.
- Safeguarding training level two was below target level for both nurse and doctors.
- There were inconsistencies in staff understanding of major incidents.

However:

- There were usually enough middle grade and consultant doctors on duty.
- Night time cover by senior doctors had increased since our last inspection.
- All middle grade doctors had completed their advance trauma life support (ATLS) training.
- There was a nurse led clinical assessment and ambulance triage process in place.
- There was increased emphasis placed on sepsis and learning.
- There was an adequate supply of equipment in the ED.

Incidents

- The trust used an electronic incident reporting system. Staff were aware of the incident reporting procedures and how to raise concerns. They told us they were encouraged to report all matters of concern, including when a shift was short staffed. Junior doctors and nursing staff showed us how they reported incidents on

Urgent and emergency services

an electronic incident reporting system. They told us that feedback was relayed during team meetings, handovers and, for staff in paediatric ED, in an incidents folder which was accessible to them.

- Fifteen serious incidents (SIs) were reported between August 2015 and July 2016. None of these were never events. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The most prevalent incident types were treatment delays (five) and sub-optimal care of the deteriorating patient (four).
- No pressure ulcers, falls with harm or urinary tract infections in patients with a catheter were reported on the Patient Safety Thermometer between June 2015 and June 2016.
- Staff were unclear about how learning from incidents was shared and did not think that there was a sharing of incidents that occurred in other departments. One senior nurse told us how purple oral syringes had suddenly appeared in ED, with laminated signs of when to use them. They told us they had a vague knowledge of an SI in another department because another nurse had mentioned it to them. However, there was no formal sharing of information and learning around this. We saw evidence of these syringes and the laminated signs which indicated how they should be used.
- We spoke with the clinical director, who acknowledged that the sharing of learning from SIs was not dealt with in a systematic manner. In response to this, a new clinical governance structure had recently been developed which was run over a four week cycle. Risks and incidents were discussed in two of these four weeks and the meeting was open to all clinicians and nurses. They told us there was an expectation that all grades of staff would be represented. We subsequently saw action plans from the two meetings which had been held to date. They had deadlines and the person responsible recorded. Some actions included 'escalate to pathology - inability to put blood results on [electronic system] between 04:30 - 06:30'. This was an action but had been resolved by the time of inspection.
- SIs were investigated by other departments, where in the past, oversight had often been by just one member of staff from within the department.
- In addition to the governance meetings, a 'governance hotspots' newsletter had been devised and we saw the first publication of this for September, to be e-mailed out to all staff. It contained information on the top departmental risk and responses to them, learning from recent incidents, complaints and clinical audits. A senior nurse told us that action plans arising out of investigation were shared in a timely manner.
- When we returned for an unannounced inspection 10 days later there was a new clinical governance board in the seminar room, which, we were told, had been put up two days earlier, and so was not populated at that time. This board was a visual display of governance issues and focus. The lay out of the board included the trust's top three risks and the departmental top three risks. Complaints, compliments and incidents were included, with themes assessed as well as hand hygiene audits. We were told that once fully established, there will be data on display of week, month and year to date performances within the department.
- Mortality and morbidity meetings (M&M) had only recently been established. The objectives of an M&M meeting is to learn from complications and errors, to modify behaviour and judgment based on previous experiences, and to prevent repetition of errors leading to complications. We were told that these meetings were to be held on a monthly basis and will be open to all staff. The departmental leadership team told us they wanted all staff to be aware of the evidence presented in this meeting in order to promote transparency and learning. The minutes of the first M&M meeting were unavailable to view at the time of our inspection.
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The trust induction programme included training in DoC. In addition, training was provided to all consultants, matrons and ward managers on an annual basis and was also included as part of the trust's two day root cause analysis (RCA) investigation training programme, and was part of the junior doctor induction programme for trainees. In addition, the risk and governance lead offered 1:1 support on an individual basis to all serious incident investigators.

Urgent and emergency services

- As a result of the last CQC inspection, various bodies, including two local clinical commissioning groups (CCGs), local authorities and the NHS England specialised commissioning body combined to monitor the trust's performance and activity and the delivery of quality services. They identified that despite RCA training, concerns remained about the use of RCA methodology and the variable quality of investigation reports. Work was being done to address this by the CCG and the medical director.
- The senior leadership team told us they were confident that DoC was addressed in an open and transparent way and they encouraged staff to see it as a collective responsibility. Staff whom we spoke with understood their responsibility in relation to this and told us it was important to them that patients trusted them to be honest in the event of any incident which might affect their safe care.

Cleanliness, infection control and hygiene

- Weekly hand hygiene audit data submitted by the trust for October 2015 to May 2016 showed that the department was usually at 100% compliance, where the trust target was 95%.
 - We were told that since June 2016, a more robust method of auditing had been introduced, which reflected lower compliance results. The expectation was that staff would understand their responsibilities with regard to proper hand hygiene, and once embedded, this would be reflected in an increased level of compliance in future audits.
 - For example, compliance for June was 90%, and July was 47% where the first two weeks were not audited. No results were posted for August as a new auditing tool was introduced. The compliance rates for the first two weeks in September were 88% and 93% respectively. Staff we spoke with told us whilst they had not instigated an action plan to address these results, they were confident that full compliance would be attained within a very short time.
 - The larger proportion of non-compliance with hand hygiene was amongst medical staff.
 - There were no cases of MRSA, C.Diff, and E Coli reported for the ED during the period of April 2015 to June 2016.
 - In the Royal College of Emergency Medicine (RCEM) audit of severe sepsis and septic shock 2013/14, the department met one standard. It was in the upper England quartile for this and three other standards.
- Neither of the two “key indicators” were met. The department performed in the lower England quartile for two other standards. It performed between the upper and lower quartiles for the remaining six standards.
- We were told that in response to this poor audit, there had been an increased emphasis placed on sepsis and learning. We saw it was discussed as a hot topic at a handover we attended. In addition, the matron told us a sepsis team was recently established. This was made up of sepsis champions (identified by a t-shirt), whose role it was to meet with the trust sepsis lead in order to keep up to date with current developments.
 - The matron told us that whilst there were good sepsis outcomes in resus, gaps had been identified in identifying the undifferentiated sepsis patient, for example where a patient presented with multiple symptoms which could mask the symptoms of sepsis. We saw minutes from a meeting which confirmed that a research student would begin a six month in October to build a safe and efficient sepsis tool.
 - We saw that the sepsis trolley had all appropriate stock equipment to deal with the septic patient. It included the departmental sepsis guidelines which identified trigger points for when to initiate treatment.
 - We observed all staff used protective clothing appropriately, regularly washing their hands and using hand gel both between patients and when moving from one clinical area to another. They complied with the ‘bare below the elbow’ guidance. All the hand gel dispensers were well stocked.
 - Most areas of the ED appeared clean and tidy and we observed domestic staff cleaning the department throughout the day.
 - However, the plaster room was in a very poor state throughout our first three inspection days. The sink was blocked on at least two of our three days on site, there were no separate hand washing facilities and no available hand towels. There were bottles of acetone and iodine left out on a work top and there were chunks of plaster of Paris lying around on the floor. We showed this to the head of nursing who set about remedying the situation. The room was in an appropriate state of cleanliness when we returned for an unannounced inspection 10 days later.

Environment and equipment

- As a result of the last CQC inspection, various bodies, including two local clinical commissioning groups (CCG)

Urgent and emergency services

and NHS England specialised commissioning body combined to monitor the trust's performance and activity and the delivery of quality services. One area of weakness identified in the CQC report was the lack of availability of suitable equipment in the department. The trust was required to submit daily audits of the replacement and maintenance of equipment.

- CQC was notified in September by the CCG that there was assurance that this situation had been rectified and audits were no longer required.
- A senior member of staff whom we spoke with said that whilst they were no longer required to submit audits, they continued to do them for their own information in order to avoid future deterioration. We saw copies of these audits and noted that shortages of equipment were recorded with a suggested action. For example, where there was a shortage of infusion pumps, a note was made to ask the porters to replace them. We saw on the audit the following day these had been replenished.
- Staff whom we spoke with told us there was an obvious increase in the provision of equipment since the last inspection, and they no longer went to other departments to borrow items. We observed there was a significant increase in equipment around the department, for example, vital observation machines.
- Documentation submitted by the trust indicated that the majority of equipment was in service, and the rest had a job reference number assigned with a service date. We saw the maintenance schedule had a maintenance date related to equipment. For example, we noted that defibrillators were next due a maintenance check in December 2016, portable ventilators March 2017 and ECG monitors in April 2017.
- We checked a selection of equipment in the adult and paediatric ED, including resus equipment, ECG machines, vital sign machines, syringe drivers and ventilators, all of which had been recently PAT tested.
- Patients complained to us about the information screen in the reception waiting area. It displayed inaccurate information about waiting times. They told us it created frustration and anxiety as they did not know when they would be seen and some wanted to go outside the reception area to have a cigarette.
- We spoke with reception staff who told us the inaccurate information led to patients getting angry with them at times.
- We spoke with an administration manager who told us work was in progress to source an alternative

information display. We saw an e-mail trail related to this with a requirement that a display board would show wait times in all parts of the ED (UCC, main ED, and paediatric ED).

- Reception staff told us the reception would benefit from having an automated counter calling system. This would enhance patient confidentiality and avoid people clustering around the reception windows.
- They said that currently they had to leave the reception desk to let relatives through to the main ED to join the patient. They suggested that a buzzer which would enable them to let the person through would be more efficient.
- The ED had recent support from an intensive therapy unit consultant who altered the layout of the resuscitation bay and rearranged the difficult airway trolley. We were told that this was of help to staff.
- We saw written evidence that daily checks were made of oxygen, suction and defibrillators. We also saw a test print on ECG machines. Requests for additional supplies were written, and noted when they were added to a stock order sheet.
- The secure room for mental health patients met the standards set out by the Psychiatric Liaison Accreditation Network. It had two doors which opened outwards, no ligature points and a viewing window. Whilst the furniture was not secured to the ground, it was too heavy to move.
- We noted that the curtains in the paediatric ED treatment cubicles were not disposable and did not have the dates on them of when they were last cleaned. The chairs in the paediatric assessment room looked in poor condition.

Medicines

- We inspected the dedicated paediatric resuscitation bay in the ED resus area and noticed that it had recently been used to treat an adult patient which was accepted practice. The area had not been cleared after this resuscitation and there were medicines and syringes lying around the bay and not disposed of in a safe manner.
- Medicines were mostly stored securely and appropriately, including those requiring refrigeration. Fridge temperatures were checked regularly and records showed that they were within the correct minimum and maximum temperatures.

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- We spoke with a pharmacy technician as they replenished supplies and they told us they did a daily stock control in ED.
- Regular expiry date checks were in place and there were suitable arrangements for ensuring medicines were available out of hours. The 'emergency' cupboard in the paediatric resus bay was secure but contained medicines that had been removed from their packaging and not stored separately, which could increase the risk of error when selecting medicines urgently.
- Controlled drugs (CDs) were stored and managed appropriately. The CDs were checked twice a day by two registered nurses. Nurses could describe the process used if patients brought controlled drugs into the unit with them, but we did not see any records of this happening. Strong potassium chloride solutions were kept within a separate CD cabinet as per the trust policy.
- Emergency medicines and equipment was available and checked twice daily in line with the policy, and a complete check was done monthly or when used. Adult emergency boxes were kept in each bay and a spare box was available to replace any used. A paediatric emergency box was also held as a spare. An emergency trolley was kept in the paediatric resus bay which was checked and maintained appropriately. However, there were no paediatric emergency medicines kept in the paediatric high dependency room which was separate from this area.
- Specific oral syringes were available in paediatric ED to enable staff to measure and administer liquid medicines safely.
- These were not available in adult A&E at the start of our inspection and we were told normal syringes would be used. However, the correct syringes and instructions were available by the end of the inspection.
- Some records in paediatric ED did not have scores recorded on the paediatric early warning system. This was raised with the ward manager who advised that there was a technical problem with one of the computers. This had been raised as an incident and reported to IT. Staff mitigated this by hand writing scores in the affected records as an interim measure.
- The flow coordinator nurse in the main ED audited 10 sets of notes per shift, and recorded the outcome on a recently introduced ED care rounding form. We looked at a sample of these forms and saw confirmation that the record included pressure area assessment, pain assessment and falls risk assessment.
- We found that allergies were documented in all cases and analgesia was prescribed in accordance with the recorded pain scores.
- There was a recently introduced mental health triage form (MHTF) and prioritisation tool in order to improve the identification of mental health risk factors at triage. We saw evidence of completed forms on patient records and staff whom we spoke with demonstrated a clear understanding of how to use them.

Safeguarding

Records

- A simple and effective system of record storage had recently been introduced and we found that records were easily accessed.
- We examined 26 sets of adult patient records and 8 paediatric patient records during our inspection to check that timely care was given to the patients. We found that initial clinical observations, such as pulse and blood pressure were always recorded. Nursing notes we looked at were clearly documented, with evidence of nutrition and hydration recorded.
- A hundred per cent of ED medical staff had completed level one safeguarding adults and safeguarding children training and 73% had completed level two safeguarding adults and 81% had completed safeguarding children training. Eighty per cent had completed level three safeguarding children training.
- Ninety-three per cent of ED nursing staff had completed level one safeguarding adults and 70% had completed level two safeguarding adults. Eighty-three per cent had completed safeguarding children training level one, 93% had completed safeguarding children level two and 84% had completed level three safeguarding children training.
- Staff we spoke with had a good understanding of safeguarding concerns for adults and children. For example, one nurse told us how they recently raised a safeguarding alert when an adult who displayed behaviours of concern, visited the department with their child. They said they could not be sure that the child would have been safe in the adult's care when they left the hospital.
- Access to information on how to report a concern was available and displayed on boards in the department.

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We saw copies of the most recent child protection policy on display and staff showed us how they accessed it on the intranet. The policy included guidance on female genital mutilation (FGM).

- The electronic patient recording system enabled staff to flag up vulnerable children and adults. They could document whether the child was known to social services, whether there was a child protection plan in place and whether there were other family issues, such as an aggressive parent.
- We saw that staff had confirmed on paediatric records that they had checked whether the child was on the local child protection register.
- Flags in relation to adults included whether the person was a vulnerable adult, elderly or had a learning disability. Flags also indicated whether the patient was known to social services, had a care plan or had a support package in place. We were shown one patient who was flagged as having a social worker and support package in place. The nurse told us contact would be made with the social worker to ensure appropriate supports would be in place when the patient was discharged.
- Staff told us the safeguarding lead nurse attended every morning to check for any overnight issues.

Mandatory training

- All middle grade doctors completed their advance trauma life support (ATLS) training by the end of June 2016. All consultants were ATLS trained.
- However, the advanced paediatric life support (APLS) certificate had expired for four of the 13 middle grades and two consultants.
- The clinical director told us in order to mitigate against this, rotas were planned to ensure there was at least one doctor with APLS on 24/7, which was monitored weekly. We checked rotas from the previous four weeks and confirmed this to be the case. In conjunction with this, APLS training was booked and the expectation was that all doctors would have APLS and ATLS by the end of the year.
- Although staff were not meeting the trust target of 95% for mandatory training, overall staff compliance had improved since the last inspection. Mandatory training for medical staff had improved from 53% in April to 80% by the end of August. For nursing staff, the figure had improved from 64% in April to 84% in September.

- All nursing staff we spoke with said there was an increased emphasis on completion of mandatory training and they confirmed they were supported to do this during working hours. Paediatric nursing staff had a rostered half day shift every month which was often used to complete mandatory training.
- Doctors and nurses told us that they had to complete their mandatory training before they would be considered for any additional special interest training. One doctor told us they were supported to embark upon a three month secondment to anaesthetics, which they said would enhance their performance in ED.
- Some staff told us they were not aware of whether there was any available FGM training, although there were examples of what staff needed to be aware of in the trust safeguarding children policy.

Assessing and responding to patient risk

- The trust recently implemented an updated resus policy in line with Resuscitation Council Standards 2016. This was available on the intranet.
- During our last inspection, we noted that there was no escalation policy for staff to implement when ED was close to or had reached capacity. During this inspection, we were shown a policy which colour coded escalation levels as green, amber and red, based on a number of factors. Amongst the factors were the number of patients in the department, number of available beds in the hospital and staffing levels. There was clear guidance on how to escalate at each level.
- Following the last CQC inspection report, NHS England (London Region) committed to take steps to reduce demand on the department during peak times in conjunction with London Ambulance Service. This included diverting 'blue light' ambulances from the trust overnight (between 10pm and 6am) from 13 July 2016. The impact on this continued to be monitored with a view to normal service being restored once there is sustained confidence in the resilience of the department.
- Patients arriving by ambulance as a priority ('blue light') were transferred immediately to the resuscitation area. The ambulance service called the hospital in advance for these cases and staff were aware of their arrival so could plan accordingly.
- At the time of our last inspection, there was a system of rapid assessment and treatment (RAT) in operation,

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which was meant to be doctor led. Lower priority patients arriving by ambulance were assessed following a handover from the ambulance crew. It was evident at the time that RAT was not working.

- In response to this, a new system was introduced two weeks prior to this inspection which was an early senior assessment and treatment model (ESAT). This was a nurse led clinical assessment and ambulance triage process, the aim of which was not to eliminate the need for onward assessment by a doctor but to enhance clinical efficiency and efficacy in the ED.
- Nurses covering ESAT were band 6 and above and appropriately trained in assessment and decision making.
- The implementation of this procedure was to help meet required improvements which could not be undertaken by senior doctors in the ED due to deficient numbers of consultants and suitably trained middle grade medical staff. The clinical director told us they anticipated revising how ESAT operated at the time when the medical establishment was stable.
- There was a medical controller role identified, one aspect of the role was to have an oversight of ESAT. In this way, the ESAT nurse would have easy and rapid access to medical support to confirm their assessment if required.
- We spent time observing ESAT and saw interactions between the nurse and medical controller as they updated each other about the current situation in the department. Ambulance staff we spoke with told us this process was a significant improvement on the previous one for consistency and responsiveness.
- However, they commented to us that there was often a shortage of hospital wheelchairs for them to transfer their patients to. This caused delays in patient handover time.
- Since the last CQC inspection in April, the trust worked with the London ambulance service hospital ambulance liaison officer (HALO) to improve patient pathways for patients taken to ED by ambulance. The focus was to reduce triage times and time to treatment across ED. Staff we spoke with described this as a positive and helpful experience.
- The report produced by the HALO was not available to see at the time of our inspection.
- The national target for ambulance handover was 15 minutes and the trust had a zero target for handovers exceeding one hour. Between April and June (13 weeks),

there was a total of 102 handovers greater than one hour, whereas this figure reduced to seven handovers exceeding one hour between July and September 2016 (12 weeks).

- During the period April to June 2016, there were 1,228 ambulance handovers greater than 15 minutes and less than one hour. There was a slight reduction in this figure between July and September, where delays totalled 1,149. We did not observe any delays in ambulance handover during the course of our inspection.
- Trusts in England have a target of triaging 95% of patients within 15 minutes of their arrival in the ED. This means that they should have an initial assessment with a nurse or doctor.
- The percentage of patients seen within 15 minutes between April and June 2016 ranged from 49% to 54% and percentages between July and September ranged from 56% to 68%.
- Whilst it was agreed that there had been a steady increase in time to triage in recent months, senior staff acknowledged that there still remained work to be done to achieve the target time to triage within 15 minutes.
- In order to improve time to triage for walk-in patients, the ED implemented a front door pathway plan in consultation with local clinical commissioning groups. There was a GP assigned to a pod in the reception area between 9am and 9pm.
- The GP was responsible for streaming the patient to the most suitable area, whether it was within the Urgent Care Centre (UCC) or in the case of a more serious condition, to the main ED. They also redirected patients away from ED to other parts of the hospital or back to their own GPs. Those GPs whom we spoke with said their target was to 'eye ball' patients within two minutes.
- We spoke with the lead emergency nurse practitioner (ENP) for the UCC. They told us the team had expanded from five to eleven members and provided 8am to midnight cover seven days per week. The trust told us there was a plan to submit a business case to provide 24 hours cover seven days a week which, at the time of our inspection, was limited to Friday, Saturday and Sunday. There was a comprehensive shift rota which ensured there were two nurses and an ENP on at all times. In addition, there were two GPs until midnight.
- The UCC had eight cubicles with two nurses triaging. One nurse prioritised patients such as those who presented with chest pains.

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- Data submitted by the trust for the UCC demonstrated that between 97% and 99.5% of patients were seen and treated within the four hour target over the preceding 14 weeks.
- Data submitted by the trust demonstrated that nursing staff attained greater than the 90% target level for assessing patients using a national early warning system (NEWS) on 22 out of 24 weeks since April 2016. Scores for the eight weeks prior to this inspection ranged between 98% and 100%. This was a significant improvement since the last inspection when 90% was attained on just five out of 15 weeks.
- We saw there was a newly devised NEWS record being introduced at the time of our inspection. This gave guidance on how to escalate, depending on the NEWS score. It included details of sepsis and also required the name of the clinician from whom advice was sought when the patient score was three and above.
- We reviewed 10 paediatric records and saw these contained nursing and medical assessments, allergies, language and family history. However, we noted that weight was not recorded on two of these records. We saw that this had been picked up in a recent audit which highlighted that children's weight was being recorded in just 50% of the records audited.
- We also noted that some records did not have a paediatric early warning score (PEWS) recorded. This was raised with the ward manager who advised that there was a technical problem with one of the computers, which did not total up the score. This matter was recorded on the electronic reporting system as an IT issue.
- We were told that nurses were hand writing the scores in patient records. When we returned to the department the following day, we saw a memo on the notice board to all staff to remind them to continue to write PEWS scores on the affected records as an interim measure.
- When we returned to the department for an unannounced inspection 10 days later, we were told that this was still a problem with one particular computer.
- Data submitted by the trust demonstrated that there was a target of 80% for patients who presented with chest pains to have an ECG within a target time of 15 minutes. Results for the previous 19 weeks showed that this target was met in 15 weeks. However, we noted that the target was not reached in three out of the most recent six weeks, when the figure dropped to between 65% and 78%.
- The clinical director told us there was no ED chest pain pathway when he started however this amongst many other pathways had now been developed.
- Following a 'prevention of future deaths' report from HM Coroner in relation to an event in 2014, the trust had put in place an action plan to improve the safety of mental health patients in the emergency department. During our inspection, we reviewed this action plan in order to establish what progress had been made.
- Most completion dates for identified actions were for the end of September, which was after this inspection. Some involved discussions with the local mental health trust regarding access to resources. We were told that progress was being made on all actions and it was expected they would be achieved by the target date.
- However, there was one action overdue, the development of a statement of purpose for escalation when a patient absconded from the department. We were told that this was delayed as it was to be included in a missing persons policy which was not yet completed.
- The trust implemented a mental health triage form (MHTF) and prioritisation tool in order to improve the identification of mental health risk factors at triage. The purpose of this was to enable high risk patients to be systematically identified so that their mental health assessment is prioritised.
- We saw evidence of completed forms on patient records, including during our unannounced inspection 10 days later. Staff whom we spoke with demonstrated a clear understanding of how to use them. They told us the forms enabled them to be clearer in their assessment of those patients who demonstrated mental health needs.
- There was no available data to assess the impact of the MHTF since they had come into use so recently.

Nursing staffing

- At the time of our last inspection, we found there was no induction programme for agency nurses. This had since been introduced and we saw that it included a

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description of the role of the agency worker and an introduction to the department. It also included policies, for example safeguarding and departmental documentation they would be expected to use.

- Full time nurses had a two week orientation which included visiting different wards, shadowing and receiving a full corporate induction.
- The substantive nursing staff shift fill rate (excluding bank and agency) was below the target rate of 90% for 15 out of the last 16 weeks, with percentages varying between 70% and 88%.
- The data submitted to us indicated that the target vacancy rate was 3%. We saw on the data dashboard that the vacancy rate in April was 12%, whereas for June, July and August it was 3%, 2% and 4% respectively.
- The departmental staffing for August was given as one whole time equivalent band 8a matron (vacancy rate 0.25), 10 band 7 ENP (vacancy 0.25) and 8 band seven (vacancy 0.6). In addition, there were 28.44 band 6 (+ 0.84), 40.41 band 5 (+ 4.38), 19.88 healthcare assistants Band 2 and 3 (+0.06). There was a budget for 16.61 agency staff and 8.72 bank staff.
- A senior nurse told us that they estimated a further 22 nurses would be required in order to sustain improvements to the ED.
- All nurses we spoke with told us there was always enough medical and nursing staff on duty and this situation had improved greatly since the time of our last inspection.
- Staff in the paediatric ED were positive about current staffing levels and commented that there was a greater medical presence in the department.
- One nurse commented that they had recently returned to work in the department 18 months after leaving and found significant improvements to the staff levels, morale and overall support staff now received from managers.
- We observed two nursing handovers, which occurred three times a day. The keys to medicines cupboards were handed over from one senior nurse to the other. Information was shared such as whether there were any blood sampling issues, the number of patients in the department and when a 12 hour breach may occur. Staffing allocations were made quickly and efficiently and all parts of the department were covered. One handover included a mini tutorial on sepsis, and 15 minutes teaching on ECGs.

Medical staffing

- As a result of the last CQC inspection, various bodies, including two local clinical commissioning groups (CCG) and NHS England specialised commissioning body combined to monitor the trust's performance and activity and the delivery of quality services.
- Their combined report confirmed they had received assurance from the trust that there were a sufficient number of middle grade doctors. The trust told us that, at the time of our inspection, staffing levels were being reviewed weekly by the operational delivery group chaired by NHS England.
- The clinical director told us that whilst there was increased recruitment, staffing remained fragile as it relied on a large amount of agency staff at present to fill shifts.
- There had been significant efforts made to increase the number of doctors in the ED since our last inspection.
- Submitted data showed that the consultant medical staff shift fill rate rose from a low of 62% in May to between 90% and 98% in the five weeks prior to this inspection. The target rate was 90%.
- The consultant establishment was increased to 14 whole time equivalent (WTE) from 12 at our last inspection. This included six full time members of staff, a paediatric consultant working full time in paediatric ED, four locums and three agency consultants. In addition, there was a supernumerary consultant on loan to the department for six months.
- There was an ED consultant who was a paediatric emergency medicine specialist and covered paediatric ED from 8.00pm to 2.00am Friday to Tuesday.
- There was consultant cover in ED Monday to Friday 8am -11pm and 9am to 11pm Saturday and Sunday. There was an on-call consultant available every day.
- Middle grade medical staff shift fill rate rose from 70% in May to 92% in six out of the eight weeks prior to this inspection with a target rate of 90%.
- There were 16 WTE middle grade doctors in the department since July, increased from 11 at the time of our last inspection. This included 13 full time members of staff, one on loan from another hospital and two agency doctors who had taken rota lines for vacant posts.
- The junior doctor fill rate dropped slightly below the target rate of 90% from a high of 98% in May to between 89% and 94%.

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Major incident awareness and training

- The trust had a major incident policy and staff told us it was included in their induction training.
- We inspected the major incident room which contained major incident equipment and up to date action cards. We found this room to be well organised and action cards up to date.
- We saw there were action cards for the security staff. However, when we spoke with one of the security staff, they did not know what a major incident was and told us they had never had any major incident training.
- There was a decontamination room, where people would be taken for example, in the event of a chemical incident. When we asked to view it, it took a member of staff 40 minutes to find the key.
- The facilities in the decontamination room were poor. There was one shower which had limited privacy, provided by a hospital screen.
- A nurse told us they had participated in a joint study day with the ambulance service about major incident response and it had been helpful.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement



We rated effective as requires improvement because:

- The unplanned re-attendance rate to ED within seven days was consistently worse than the national standard.
- The department did not have a frailty pathway.
- The appraisal rates for doctors and nurses were low.
- The provision of food and drinks for patients after 10pm was inconsistent.
- Multi-disciplinary work with other specialisms was not embedded.

However:

- Patients were offered pain relief in a timely manner.
- Staff demonstrated a good understanding of MCA and DoLS

Evidence-based care and treatment

- The department used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment they provided and local policies were written in line with these.
- We saw that the paediatric ED followed certain protocols such as asthma, dehydration and head injury. They also followed NICE guidance for identifying risk of serious illness.
- We saw there were several pathways accessible to all staff on the intranet and came up as the front page for ease of access. Some of these included fracture of neck of femur, neutropenic sepsis, asthma, management of adult paracetamol overdose, anaphylaxis and stroke CVA and TIA.
- However, the clinical director told us that there was a need to develop more pathways, including a frailty pathway.
- Local audits were carried out, including hourly rounding, completion of NEWS and patient records.
- The department had just begun to audit sepsis screening, and timely administration of medicines and fluids in September which meant that there was no available data at the time of our inspection.

Pain relief

- All records seen had a pain score recorded and records confirmed that people received pain relief in accordance with their score. People we spoke with also confirmed they received analgesia in a timely manner.
- The paediatric ED used the Wong-Baker smiley faces pain rating tool, an age appropriate tool, to record children's pain levels. We observed a paediatric nurse as they recorded children's pain scores, using this visual tool.
- A parent told us their child's pain level was assessed straightaway by a nurse and the child settled very quickly as a result.
- An adult patient told us how nurses were sympathetic to the high level of pain they were experiencing and regularly checked whether more pain relief was required.

Nutrition and hydration

- The department had a budget for 1.64 whole time equivalent (WTE) housekeepers. Data provided to CQC showed that two WTE housekeepers were employed.

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- Part of the housekeeper role was to provide patients with fluids and food on a regular basis. The shift pattern was such that there was no housekeeper cover between 3pm and 7pm, and between 10pm and 7am. There was no cover at weekends.
- We spoke with a housekeeper who told us that it was difficult to get extra supplies from the main kitchen. Sandwiches were supplied on a patient by patient basis, which did not allow for sudden surges after the housekeeper had left ED.
- A senior nurse told us that the provision of food and drinks in the evening was poor and the facilities department did not make allowances for evening or night time patient attendances. It was difficult to get patient specific requirements such as thickeners or special dietary needs.
- Drinks for patients and relatives in paediatric ED were from jugs, rather than a water dispenser. We spoke with staff about this and they said that their preference was for a water dispenser, however, there had been difficulties with this. Unsupervised children had made the area very wet and thrown the cups around on several occasions, causing a slip hazard. They told us they were uncertain whether alternative options were being explored.

Patient outcomes

- Between May 2015 and April 2016 the unplanned re-attendance rate to A&E within seven days was consistently worse than the 5% standard and the England average of 7.73%. However, between April and September 2016 this rate had improved and although still worse than the standard, the rate was consistently better than the England average. Re-attendance rates were consistently between 6.2% and 7.4% for 24 out of the 25 weeks between April and September 2016, rising to 8.1% on one occasion. Staff were aware of this and told us one possible explanation was the high proportion of the local population who were not registered with a GP and returned to the hospital for reassurance following their recent attendance.
- In the Royal College of Emergency Medicine (RCEM) audit of severe sepsis and septic shock 2013/14 (most recent figures) the department met one standard (vital signs measured and recorded in the ED notes) . It was in the upper England quartile for this and three other standards. Neither of the two “key indicators” were met.

The department performed in the lower England quartile for two other standards. It performed between the upper and lower quartiles for the remaining six standards.

- In the RCEM audit of asthma in children 2013/14, the department failed to meet any of the standards. It performed in the lower England quartile for four standards. It performed between the upper and lower England quartiles for the remaining six standards.
- ED took part in the RCEM Vital Signs in Children Clinical Audit 2015-16, analysis of which was, ‘there is much good practice demonstrated in this audit, with high numbers of patients being assessed by more experienced ED staff.’
- Results of the audit outlined the need for increased documentation of both initial and repeat vital signs within the timeframes stated in the standards, which is within 15 minutes of arrival or triage and 60 minutes for the repeat. We saw evidence that this was happening. The audit stated that documentation regarding the recognition of and acting to address the abnormal signs was generally good.
- However, it was also written that it was important that children with persistently abnormal vital signs were reviewed by a senior doctor before being discharged home. It was not clear from our discussions with staff whether this happened.

Competent staff

- Doctors and nurses we spoke with told us they followed guidance from the National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) in their practice.
- Junior doctors told us they felt well-supported and had access to training. There was protected time allocated for teaching and on one occasion during our inspection, junior doctors were all off the floor in a three hour training session with a senior clinician.
- The clinical director told us there was a need to embed training within the department. They had begun to work with Health Education England to develop a training plan for all staff and with the deanery to develop a programme around leadership and management for middle grade doctors.
- The matron told us how there was a new focus to build in management time for band 7 nurses in order to develop their training in team management.

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- We spoke with a nurse employed by ED as a consultant whose role it was to help evolve and improve service delivery in ED. Part of this work was to look strategically at pathways and processes internal and externally to the department. It was also to empower and support junior staff to deliver changes.
- There was a steady increase in appraisal rates for nurses since the last inspection, when completion rates were between 37% and 50%. Recent figures were still below the 90% target rate and ranged between 56% - 63% in June to 75% - 79% in August.
- There was a significant deterioration in appraisal rates for medical staff from 100% between January and May to 40% for June and July. There were no figures available for August.
- Suggested reasons for this were that there had been no clinical leadership of the department for some time and therefore no oversight of appraisals, and it was unclear how the 100% rate was measured.

Multidisciplinary working

- Nurses we spoke with told us that there were still weaknesses in internal multidisciplinary team working (MDT) as identified in the last report. We were told that there was, on occasion, poor and late clinical decision making, depending on the consultant in charge.
- We spoke with the clinical director who acknowledged that there remained certain poor practices which affected the efficiency of the department and, at times, patient safety in the department. They told us they were working in conjunction with the human resources department to address this.
- Paediatric ED nurses told us they felt supported by doctors in the main ED department. In addition, the medical director had allocated a consultant, who was a paediatric emergency medicine specialist, to the paediatric ED from 8pm to 2am Friday to Tuesday.
- We were told that there had been an improvement in MDT working with other departments within the hospital, though there were still some areas of weakness.
- In response to this, the policy 'internal professional standard emergency department referral & admission' which was developed in October 2015, was being revisited in order to remind other departments of their responsibilities in relation to ED and to help patient flow through ED.

- The policy stated that a referral from ED to a specialty should be immediately accepted. Any disagreements should be dealt with at consultant level and patients would be directed to the appropriate assessment unit within 30 minutes, and reviewed with a decision within 60 minutes of acceptance.
- The on-site presence of a mental health liaison team ensured those patients presenting with mental health issues were appropriately managed and in a timely manner. Staff both from the mental health team and ED staff spoke positively of the good working relationship there was between the two disciplines.
- The trust part funded two youth workers from a local charity, who were based within ED. Their remit was to offer support to those attending with injuries from gang violence. A nurse in paediatric ED told us they found the support from the youth workers to be invaluable and said there were times when their input had diffused potentially violent situations breaking out in ED. These youth workers came to the paediatric ED twice a week to support and train staff on topics such as gang violence.
- Staff in paediatric ED told us there were frequent delays in moving a child with a mental health illness to a more appropriate setting, to be supported by the child and adolescent mental health service (CAMHS). They recognised that this was not just a local issue, however, the impact on patients was significant. For example, we were told there was a 15 year old patient in an ED cubicle for four days, until a bed could be found in a specialist facility.

Seven-day services

- There was a GP project based in the urgent care centre (UCC). This included two GPs whose role it was to see and direct walking patients between 9am and 10pm, seven days a week.
- Separate to the GP project, the UCC operated 24/7. This was made up of a team of 11 and led by an emergency nurse practitioner and had two GPs who worked until midnight.

Access to information

- We found that access to records was better organised since the last inspection. A simple but effective filing system had been introduced in ED which ensured that patient notes were easily tracked.

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- The ED recorded patient notes on paper records, and there were no immediate plans to become paperless.
- There was an electronic system which tracked patients within the department and which staff updated as the patient progressed through from triage to treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training was included in the mandatory e-training program as part of safeguarding level one training for medical and nursing staff. It is also included in the level two face-to-face safeguarding adult training.
- Staff we spoke with demonstrated an understanding of the requirements of the MCA.
- DoLS provide legal protection for those vulnerable people aged 18 and over who are, or may become, deprived of their liberty in a hospital or care home. We spoke with the mental health service manager who told us they ran MCA and DoLS courses every two to three months for ED medical and nursing staff.
- Staff whom we spoke with told us there were no formal MCA or DoLS assessment tools in place for ED patients.
- We saw that it was routine practice for staff to ask patients for their verbal consent before conducting any assessment or treatment procedures.
- We heard medical and nursing staff give full explanations of how the patient's examination would be carried out, and consent was sought at each part of the process.

Are urgent and emergency services caring?

Good



We rated caring as good because:

- Staff provided compassionate care and ensured patients were treated with dignity.
- Patients spoke positively about the care they received and the attitude of kind and considerate staff.
- Patients and their relatives and families were kept informed of on-going plans and treatment. They told us that they felt involved in the decision making process and had been given clear information about their treatment.
- Staff had access to resources to assist them in offering emotional support to bereaved relatives and were able to direct relatives to external agencies for additional support.

Compassionate care

- The trust acknowledged that it struggled with ED NHS Friends and Family Test (FFT) response rates, particularly for A&E. Reasons given for this included disruptions with the text messaging service (which has now been rectified) and ongoing difficulties with theft of response collecting equipment.
- We spoke with 36 relatives and patients, the majority of whom told us they were satisfied with their care. One said, "I think the staff are really caring here – they do a good job trying to please everyone." Another said, "Staff have been very professional and reassuring to me as they saw I was upset" and "I felt the doctor really wanted to understand my concerns."
- A relative told us, "They are wonderful staff here, so friendly. The paramedics called ahead and we were seen to straight away. I have no complaints."
- We spoke with a parent in the paediatric ED who told us "my child was given an inhaler to go away with which meant that I did not have to delay on my way home to go to pharmacist."
- We observed compassionate care delivered by nurses and doctors, to patients. Staff engaged in an open and positive way with patients and their relatives. We saw how a nurse spent much time comforting an elderly patient who said they were very worried about their illness.
- Another time, we saw how nurses dealt with a very challenging patient in a way which afforded the patient dignity and respect. They demonstrated a very caring attitude and an understanding of why that patient was so upset.
- However, some of the negative comments included the speed with which the GP based in the pod dealt with them. They told us it was not explained clearly to them that this was solely a streaming process and therefore they had expected a full consultation.

Urgent and emergency services

- General observations confirmed staff respected the privacy and dignity of patients. Curtains were closed around cubicles and those patients who were on trollies in the corridor awaiting a cubicle were covered up with a blanket. We did not hear any confidential patient matters discussed publicly.

Understanding and involvement of patients and those close to them

- Most patients told us they felt informed about the processes in ED. They said that once treatment had started, staff dealt promptly with their needs and most felt very confident about the explanations and care they received.
- Parents accompanying their children in paediatric ED were positive about the treatment their children received. They said the nurses and doctors understood them and were supportive. One told us “even though my child is very young, the doctors and nurses went to great lengths to explain to them what was going on.”

Emotional support

- There was a trust wide diverse chaplaincy team which reflected the diverse needs of the local population. It included Jewish, Christian, and Muslim chaplains. There was an on-site chapel, a multi-faith room and a Muslim prayer room.
- The ED staff had a protocol on how to deal with relatives who experienced bereavement and the hospital chaplain could be contacted as requested. Representatives from other faiths could also be contacted by staff on behalf of the bereaved.
- A booklet, ‘Practical help following the death of a relative or friend’, was given to all bereaved people. It contained information on how to access the Chaplaincy, an explanation in the event of a post mortem and how to register the death.

Are urgent and emergency services responsive to people’s needs?
(for example, to feedback?)

Requires improvement



We rated responsive as requires improvement because:

- The ED was not meeting the target time to admit, transfer or discharge 95% of patients within 4 hours of their arrival in the ED.
- Patients frequently waited in the ED for a number of hours until a bed became available on a ward.
- The department was responding to most complaints within the agreed period although most staff we spoke with were unable to tell us about any learning or changes implemented because of a complaint.
- Staff did not have specialist knowledge of the needs of patients who lived with dementia or patients with a learning disability.

However:

- There was evidence of improvements made to the four hour performance in August, which was between 92% and 87% for three weeks in September, which exceeded the national average of 82%.
- Two rooms on the observation ward were designated for less ill mental health patients.
- The clinical governance board in the seminar room displayed complaints, themes and learning.

Service planning and delivery to meet the needs of local people

- The trust had initiated the NHS England Faster, Safer, Better programme in May 2016, designed to develop good practice in delivering urgent and emergency care. The focus of this was to make improvements in flow, discharge planning and preventing admission in and out of hospital.
- A 'see and redirect' service was set up, run by local GPs. The focus of this was to either redirect the patient to their own GP or in the event of the patient not registered with a GP, assist them with the process of registration.

Meeting people’s individual needs

- The department catered for a culturally diverse population in which many different languages were spoken. There was a telephone and face-to-face interpreting service available. However, staff told us they hardly ever used the face-to-face interpreter service, as there was usually someone with the patient to interpret.
- Reception staff told us some of them spoke different languages which helped when dealing with patients.

Urgent and emergency services

- There were on-site psychiatric liaison nurses available to provide a rapid response visit to the department when needed. Over the course of our inspection, we saw members of the psychiatric liaison team in the ED, assisting patients with a mental health illness.
- There was a family room where the bereaved could sit which had tea and coffee making facilities. We noticed that one of the arms of the sofa was badly ripped.
- There was a viewing room next to the family room where family members could spend time with their deceased relative.
- There was a secure room for mental health patients which met the standards set out by the Psychiatric Liaison Accreditation Network. It had two doors which opened outwards and a viewing window. The furniture, whilst not secured to the ground, was too heavy to lift or move and there were no ligature points in the room.
- Prolonged waiting times for a suitable bed in a mental health hospital meant patients frequently stayed longer than 12 hours in ED, thus causing a breach. This was evident on our inspection when we saw a patient waited over 14 hours to be transferred out to a specialist hospital. This was beyond the control of ED staff as the patient transfer was managed by the psychiatric liaison service which had a difficulty in locating a bed.
- Senior staff told us in order to improve patient experience and safety, two rooms on the observation ward were designated for less ill mental health patients and adapted to be ligature safe. An agency registered mental health nurse (RMN) would be employed to manage the patient on the observation ward. If not immediately available, the matron told us they would increase ED nursing support until the RMN arrived.
- We observed this in practice when we returned for our unannounced inspection. An RMN arrived at 8am to 'special' a patient who had been in ED from 2am. The nurse in charge did a comprehensive handover and orientation of the department and was then introduced to the patient.
- There was no asthma specialist nurse in paediatric ED. A nurse we spoke with told us an asthma specialist would enhance patient experience and help to reassure and educate parents and carers.
- There were no designated champions for people with a learning disability in ED.
- Staff could not recall using any tools specific to patients with a learning disability. For example, they did not have any communication tools for patients with limited communication.
- Patients with a learning disability had a hospital passport, which included information about them. This included things staff must know about the patient, things which were important and the patient's likes and dislikes. Nurses we spoke with told us they referred to this document whenever it was shared with them, though not all patients who came into the department always had one with them.
- One local authority Learning Disability Partnership introduced a 'purple folder' which included the patient's health action plan. Any treatment issued to the patient should be recorded in the purple folder. Some staff were aware of the purple folder but said they had not had a patient who come in with one.
- The trust developed a dementia strategy action plan at the beginning of 2016. Amongst the actions identified was that the senior clinical lead for dementia should ensure that a named healthcare professional acted as a point of contact for people with dementia and their families during the admission to hospital. The update on the information submitted to CQC stated that there were dementia champions in place.
- However, staff we spoke with were not clear whether there was a designated champion for people living with dementia in the ED.
- Another action from the plan was that 100% of staff should have basic dementia awareness training and updates. The update on data submitted to CQC was that there was training in place, but it needed to be performance reviewed. This meant that there was no definitive data to corroborate this at the time of our inspection.
- Some staff we spoke with said, whilst they tried very hard to engage with a person living with dementia, they did not always feel confident they had the skills to do this to the best of their ability.

Access and flow

- At our last inspection the trust was unable to tell us how they captured the 15 minutes to triage. Recent data submitted to us for this inspection demonstrated that this was being routinely captured.

Urgent and emergency services

- The average time to triage in the 21 weeks since May was 13 minutes, with two breaches of 16 minutes in the same time period.
- As a result of the last CQC inspection in April, various bodies, including two local clinical commissioning groups (CCG), local authorities and NHS England specialised commissioning body combined to monitor the trust's performance and activity and the delivery of quality services.
- This monitoring body reported to CQC that there had been a steady improvement in the trust's performance against the 4 hour wait target since the last CQC inspection. This was attributed to factors which included the new leadership in ED, additional senior medical support secured by NHS England, and the Trust's Safer Faster Better transformation programme.
- Trusts in England are given a target by the government of admitting, transferring or discharging 95% of patients within 4 hours of their arrival in the ED.
- Our last inspection identified that the department consistently breached the four hour ED waiting time, with rates as low as 65% between August 2015 and May 2016.
- Data submitted to CQC indicated that whilst the 95% target was attained only once in the 21 weeks between May and September 2016, the average performance for June was 77%, July 90%, August 92% and 87% for three weeks in September.
- The 95% target was achieved in paediatric ED in 16 weeks over the same time period and dipped no lower than 93%.
- Staff told us the majority of breaches were due to lack of flow throughout the hospital, with no available beds to move patients out of ED.
- On the first day of our inspection, an internal incident was declared when there were no beds available in the hospital at 10am to admit further patients. This was escalated throughout the hospital and we subsequently were told that there were 38 beds available in the hospital by 3pm.
- We attended a 10am bed management meeting during our unannounced inspection 10 days later. We heard during this meeting that there were just two confirmed patient discharges throughout the hospital, with a further 32 potentials. A senior manager pronounced this as unacceptable and requested that discharge was prioritised in order to meet the inevitable demand for beds later in the day.
- We observed very few four hour breaches during our inspection. For example on one early morning visit, we confirmed there had been 90 patients into the department since 10pm the previous evening. There were 19 patients in ED at the time of our arrival at 6am, with three patients waiting over 4 hours.
- There were 97 patients in the department at 3pm on one of our inspection days, with the longest wait 2 hours and 18 minutes. There were five breaches of over four hours, these included two patients with a mental health illness awaiting a mental health assessment, two had a decision to admit and were waiting for beds; and one was waiting for investigations due to a delayed blood test which was not done within first hour of arrival.
- On our early morning unannounced inspection there had been 399 patients through the department in the previous 24 hours, and 89 since 10pm. There were 23 patients in the department at 6:15am, with three breaches. One breach was a patient with a mental health illness awaiting a psychiatric assessment, another was an elderly patient waiting for transport to go home and one breach was a patient waiting to be seen by a physiotherapist who did not start work until 9am.
- There was one 12 hour breach in decision to admit in the 21 weeks since May 2016.
- The percentage of patients leaving before being seen was consistently higher than the England average between May 2015 and April 2016 (most recent data available).

Learning from complaints and concerns

- There were 29 formal complaints raised in ED since May 2016 of which five were against staff.
- Senior staff told us they were aware that complaints made against ED were not consistently shared with staff throughout the department.
- To mitigate against this, two out of the four week cycle of the newly structured clinical governance meetings included reviewing and acknowledging complaints. Complaints would be displayed on the recently erected clinical governance board in the seminar room for all staff to see. Learning and trends would be identified and also displayed.
- Staff told us that there had been an improvement in the sharing of complaints which were more frequently fed back at handovers.

Urgent and emergency services

- We saw an analysis of complaints in paediatric ED which showed waiting times and staff attitudes were the issues most complained about. We also saw that these issues were discussed with staff at handover, where staff were reminded about the importance of good communication with families. They were encouraged to use the situation, background, assessment and recommendation technique (SBAR), which can be used to facilitate prompt and appropriate communication.

Are urgent and emergency services well-led?

Good



We rated well-led as good because:

- Staff felt supported in their roles by the new departmental management team.
- Operational managers and clinical staff worked together as a team to address the challenges faced by the ED on a daily basis.
- There was clear nursing and medical leadership visibility with the department, and staff felt able to highlight issues to them.
- There were new governance arrangements which were transparent and robust.

However:

- The sustainability of departmental improvements was heavily dependent upon the recruitment and retention of medical staff in particular, rather than reliance upon loans and secondments from other hospitals as was the case at the time of this inspection.
- Staff expressed some uncertainty about the implications for them in relation to the newly developed relationship with another trust.
- There appeared to be very limited resources for planning and undertaking a program of clinical audit based on trust wide key patient safety policy areas such as falls and pressure ulcers.

Leadership of service

- The department was led by a clinical director, a head of nursing and a business manager. The nurses and doctors we spoke with were all clear about their lines of management and supervision.

- Senior managers told us the key to the sustainability of the department was teamwork and a sense of shared responsibility both within and outside of the department.
- We observed good leadership skills during handovers. There was clear communication with junior staff regarding their role and responsibilities for the shift. We saw consultants give explanations and support to junior staff in decision making for patient treatment. Senior nurses allocated areas of supervision and responsibility to nurses during handover.
- There was on-going oversight of how the ED functioned and flowed throughout the day, monitored by the nurse in charge, the nurse flow coordinator and the medical controller.
- We saw the department's audit plan for 2016/17 which listed eight audits including three RCEM audits for asthma, consultant sign-off and severe sepsis and septic shock. There appeared to be very limited resources for planning and undertaking a program of clinical audit based on trust wide key patient safety policy areas (e.g. falls and pressure ulcer prevention assessments, nutrition assessments).
- Lack of staff capacity was identified as a key factor, with the clinical audit team currently consisting of only one full time member. There had also been an issue of work not being fully or accurately recorded. The trust medical director advised that they would now be working to address the structure of clinical audit in order to fulfil the functions required.
- Doctors and nurses we spoke with told us they believed there was a greater emphasis on the delivery of quality care over what had previously been financially driven decisions.

Vision and strategy for this service

- Members of the senior management team told us their vision for the department was to make it a consistently safe place for patients to receive treatment and to provide them with a better patient experience.
- They also told us they wanted the ED to be viewed by the local community in a positive light and as a place to which staff enjoyed coming to work in.
- We were told the last CQC inspection in April was a catalyst for change and this was seen in a very positive light. Senior managers said they felt excited about the future of the ED.

Urgent and emergency services

- During our last inspection, staff did not feel that the trust values were being upheld by the executive board and senior managers. Some told us at that time that they could not wear their lanyard with the trust values on them as they felt they were meaningless.
- We noticed a major shift in staff attitudes during this inspection. Most people we spoke with expressed a sense of optimism and a collective responsibility for the future success of the ED.

Governance, risk management and quality measurement

- Managers told us the three top risks in ED were the achievement of 4 hour target, achieving sustainable robust nursing and clinical staffing levels and competencies and the consistent delivery of 15 minutes to triage.
- Managers told us that good governance was essential to build a safe and effective department.
- A new clinical governance structure had recently been developed which was run over a four week cycle. Risks and incidents were discussed in two of these four weeks and the meeting was open to all clinicians and nurses. At the time of our inspection, this structure had been in operation for four weeks and we looked at minutes from the two meetings already held.
- The agenda included a review of the risk register, with updates on recent risks and the key messages to be communicated to staff. Incidents were covered, and included reviews of 48 reports, themes and learning. We saw that action plans from these meetings had named staff against all agreed actions and clear deadlines set.
- Staff were aware that managers had begun to introduce a new governance methodology which would make risk management and quality measurement more transparent. They were able to articulate the new departmental governance arrangements and which individuals had key lead roles and responsibilities within ED.
- When we returned for an unannounced inspection 10 days later, staff could tell us about a new clinical governance board which had just been erected in the seminar room. They told us that this would help them to better understand the governance issues faced by the department. They also said this transparency gave rise to a shared sense of responsibility towards good governance.

- Staff told us there were clear lines of responsibility within the department which they said gave an air of confidence and safety to the department.

Culture within the service

- We found there was a noticeable change with the culture of the department since our last inspection in April. Staff spoke with energy, enthusiasm and optimism about the future of their ED. They told us they felt they valued by their managers and believed they and had a voice with which to make suggestions and raise concerns without fear of being criticised for doing so.
- Staff told us they believed there was a new culture of openness and transparency with the executive board, and it was clear which the direction the hospital should go in.
- However, there was some concern expressed about the implications for staff in relation to the newly developed relationship with another trust.
- Staff said the increased numbers of staff had boosted morale throughout the department and demonstrated a commitment to their department by the executive board.
- Most staff had already met the new chief executive at least once since her appointment in July. They said her visibility gave them confidence that the ED would get the support to become 'a great department once again.'
- Staff told us the leadership provided by the clinical director, medical director and director of nursing made them feel the necessary improvements were a shared responsibility.
- Nurse and doctors spoke positively about the way in which the clinical director supported them and believed they were a strong advocate for them and the department as a whole.
- Nursing staff told us that the new director of nursing, in addition to the assistant director of nursing and the head of nursing, made for a robust nurse leadership team, which modelled good working practices.
- We observed good team working between doctors and nurses. However, some nurses told us there were still some consultants who were reluctant to fully engage with patients in the department. They told us they were expected to encourage and remind some consultants about their responsibilities.

Public and staff engagement

Urgent and emergency services

- The department's performance in the NHS Friends and Family Test was consistently worse than the England average between September 2015 and June 2016. There was a steady decline in the percentage of people recommending the department which was consistently below 50%. This figure rose to 51% in August.
- We were told that matrons and nurses meetings had recently been reinstated. We received copies of the most recent matrons, band 6 and band 7 meeting minutes. We saw that band 6 attendances at meetings were noted as poor.
- We were told about a project which some band 6 nurses were working towards to move the department towards electronic prescriptions. They were in the process of developing a business plan for this.

Innovation, improvement and sustainability

- The development of 'grab bags' for adolescents was a new initiative developed by the named doctor and paediatric ED lead, in conjunction with a multi-agency steering group. The grab bags included condoms, sexual health advice, homelessness and missing persons information. There was also a child sexual exploitation leaflet developed by young people, information about drugs, mental health services, consent and exiting gangs information. The contents of the grab bag were developed based on the outcome of a focus group

made up of young people. They were designed with 12-18 year olds in mind. A nurse we spoke with told us they exercised caution when considering giving them to the younger age group.

- Women who attended the ED with problems related to female genital mutilation (FGM) such as recurrent UTIs, urinary retention and psychological issues were offered direct referrals to a new FGM clinic. The FGM clinic consisted of a multi-disciplinary team consisting of a paediatrician, obstetrician, specialist midwife and psychologist. This service met all the requirements as recommended by the NHS England FGM Steering Committee.
- Two youth workers had recently been placed in paediatric ED, jointly funded by the trust and the Mayor's office for policing and crime. All under 25s who attend with confirmed or suspected gang related injuries including stabbings are offered referral to these youth workers.
- New safety netting leaflets were developed to give to parents who may not know when to return with their children who were ill. We saw these leaflets covered information on minor illnesses and injuries and were readily available in the paediatric ED.
- Senior managers whom we spoke with were clear to say that whilst they believed the department was moving forward and improving service delivery, sustainability was dependent upon the continued recruitment of good quality staff.

Medical care (including older people's care)

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

Information about the service

North Middlesex University Hospital is an acute hospital with 293 inpatient beds providing a range of medical care services. These services include cardiology, respiratory medicine, general medicine, stroke, medical oncology, gastroenterology, endocrinology, nephrology and older person's medicine.

In the period 1 March 2015 to 29th February 2016 North Middlesex University Hospital admitted 29,921 patients; of these 37% were general medicine cases, 19% clinical oncology cases and 17% gastroenterology cases.

We inspected the acute assessment unit (AAU), acute medical unit (AMU), acute stroke unit (ASU), older person's wards (Charles Coward, Michael Bates, Pymmes Zero), respiratory ward (Tower Ward 5), medical oncology ward (Podium Ward 1), gastroenterology ward (Tower Ward 6), endocrinology (Tower Ward 7), nephrology ward (Tower Ward 8), the endoscopy unit, day hospital and discharge lounge.

We visited the medical service at North Middlesex University Hospital for two and half announced inspection days and on two unannounced inspection days at the weekend and during one evening. During the inspection visit we spoke with 39 patients including their family members and carers, 27 staff members including nurses, doctors, consultants, senior managers, therapists, and support staff. We observed interactions between patients and staff, considered the environment and looked at 19 care records. We received comments from our listening event and from people who contacted us to

tell us about their experiences. To support information provided by staff during the visit, we reviewed documentation and computer based information. We also requested and reviewed additional documentary evidence during and following the inspection.

Medical care (including older people's care)

Summary of findings

We rated this service as requires improvement because:

- Staff understood how to report incidents, however these were not always reported through the online reporting system and there appeared to be no formal process for feeding back to staff. Mortality and Morbidity review meetings did not always identify action points or lessons learnt.
- Patient records had not been completed consistently, frequency of intervention was not always recorded and there was no evidence that the care of patients had been increased to reflect individual needs. Patient records were not always kept confidential or stored securely.
- There were adequate supplies of personal protective equipment (PPE); however staff did not always wash their hands between patients and wear gloves or aprons.
- Staffing levels on the wards did not always reflect the safer staffing acuity tool to determine safe staffing levels.
- Nursing staff we spoke with did not know about the settings for the pressure relieving mattress. They were unable to tell us how they set them up and staff showed no understanding of what the warning lights meant.
- Compliance with mandatory training was below the trusts target for infection prevention and control training, health safety and welfare, information governance, safeguarding, safeguarding children and fire safety.
- The trust participated in national audits which showed the trust's performance was below the national targets and the hospital was achieving variable outcomes for patients compared with the national average. These included the Sentinel Stroke National Audit Programme (SSNAP), the Myocardial Ischemia National Audit Project (MINAP), and the National Diabetes Inpatient Audit (NaDIA).
- At weekends a consultant was only available on site from 9am to 8pm to see new admissions and seriously ill patients. However, outside of these hours an on-call consultant provided cover.

- Food and fluid charts were in place for patients who required monitoring, however we found that staff had not always completed these charts appropriately and accurately which could affect patients' care and treatment. Feeder cups and meals were not always left within easy reach of patients.
- Staff knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards was variable. Mental Capacity Act 2005 (MCA) and DoLS training was not part of the trust's mandatory and statutory training programme. We saw that patients' Deprivation of Liberties Safeguards (DoLS) applications had expired and patients were still subject to restraint. Staff did not always ask patients permission before care or treatment was given.
- We spoke with 39 patients and their relatives about their experience. The feedback from patients indicated staff were not providing good care and treatment.
- Patients were not treated with dignity and respect; we observed staff speaking unkindly and in a patronising way to patients.
- Nursing staff and doctors did not always introduce themselves or tell the patients what they were doing.
- Feedback from relatives was mixed.
- We found no evidence of activities such as cards, games or puzzles on the care of the elderly wards.
- We looked at 15 sets of patient records. We found that nursing assessments and care plans were mostly incomplete. This meant that patients' care needs were not all identified and that patients could be receiving care that was not appropriate to their needs.
- The percentage of patients that started consultant led treatment within 18 weeks was consistently lower than the England average of 90%.
- The trust reported the total number of bed moves across the medical wards at night between the hours of 10pm and 6am was 315. The largest number of moves involved patients in general medicine 54.6% (172) and care of the elderly 16.5% (51).
- The average length of stay was longer (6.1 days) than the England average (3.9 days) for elective care between March 2015 and February 2016.
- Staff we spoke with told us that they rarely had feedback about complaints or learning from them.

Medical care (including older people's care)

- The trust had a dementia strategy in place; however, of the 23 action points seven had been completed and 16 remained outstanding. The trust had not prioritised the dementia strategy; however since the arrival of the new executive team this was beginning to change.
- Complaints were discussed at monthly clinical governance meetings. We saw that complaints were monitored and outcomes recorded with details of action points and learning identified. However, Monthly ward meetings did not disseminate learning from incidents or complaints.
- The trust had a zero tolerance policy for staff speaking in languages other than English. We observed this on some wards and saw no action was taken to address this.
- Staff we spoke with that worked on Pymmes Zero ward told us that they had not been involved in any of the refurbishment plans to make the ward dementia friendly. However, we were told by the trust that the ward manager and matron for Pymmes Zero ward had been involved in planning the refurbishment.

However:

- Most staff were aware of their responsibilities under duty of candour.
- We found that medicines were generally stored securely and appropriately, including those requiring refrigeration. Regular expiry date checks were in place and there were suitable arrangements for ensuring medicines were available out of hours.
- Staff had access to the trust's safeguarding policy via the trust intranet and knew how to access the safeguarding team for advice and guidance when required.
- Multidisciplinary (MDT) working was evident on medical wards. There was evidence of an MDT approach to discharge planning. Patients had access to the full range of allied health professionals such as speech and language therapists, dietitians, tissue viability and diabetic nurses.
- Endoscopy, diagnostic services including imaging, physiotherapists and occupational therapists and pharmacy services and laboratory were available seven days per week.

- Most staff had received an appraisal. The trust reported 84.5% of nursing staff within the medical services had received an appraisal. This was above the trust target of 80%.
- Patients we spoke with told us they felt involved in their care and understood their treatment and care plans.
- The trust used the Friends and Family Test (FFT) to gather patients' views on whether they would recommend the service to family and friends. Overall, these showed satisfaction with the service, with the medical wards ranging from 58% to 100% during the period.
- The hospital admitted patients for the day so that they could undergo tests. Relatives either brought patients in or the hospital arranged for patients to come via the patient transport service.
- Staff in endoscopy had identified Turkish, French and Polish as the most commonly spoken languages other than English amongst their patients. To meet their needs information leaflets about preparing for endoscopic procedures were available in these languages.
- Staff told us that some members of the new executive team were visible on the wards, some staff we spoke with felt more confident that things were changing.
- The leadership team responsible for the endoscopy unit had included staff at all levels in plans for the temporary move of the unit, including how the unit would operate on their return after the refurbishment.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement 

We rated safe as requires improvement because:

- Staff understood how to report incidents, however these were not always reported through the online reporting system and there appeared to be no formal process for feeding back to staff.
- Mortality and morbidity review meetings did not always identify action points or lessons learnt.
- Patient records had not been completed consistently, frequency of intervention was not always recorded and there was no evidence that the care to patients had been increased to reflect individual needs. Patient records were not always kept confidential or stored securely.
- There were adequate supplies of personal protective equipment (PPE); however staff did not always wash their hands between patients and wear gloves or aprons.
- Staffing levels on the wards did not always reflect the safer staffing acuity tool to determine safe staffing levels.
- Nursing staff we spoke with did not know about the settings for the pressure relieving mattress. They were unable to tell us how they set them up and staff showed no understanding of what the warning lights meant.
- Compliance with mandatory training was below the trusts target for infection prevention and control training, health safety and welfare, information governance, safeguarding, safeguarding children's and fire safety.

However:

- Most staff were aware of their responsibilities under duty of candour.
- We found that generally medicines were stored securely and appropriately, including those requiring refrigeration. Regular expiry date checks were in place and there were suitable arrangements for ensuring medicines were available out of hours.
- Staff had access to the trust's safeguarding policy via the trust intranet and knew how to access the safeguarding team for advice and guidance when required.

Incidents

- There were 1,538 incidents reported under the medicine directorate between July 2015 and June 2016, all information under this section relates to incidents reported within this period.
- There were 19 serious incidents and no never events for the period August 2015 to July 2016. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. In clinical governance meeting minutes we saw that serious incidents were discussed.
- There were 407 incidents logged as falls with 86.2% (351) resulting in no harm, 12% (49) low harm and 1.7% (7) moderate harm across medicine and the specialities. The largest number of falls were recorded in general medicine 49.6% (202) and care of the elderly 44.4% (181).
- There were 218 incidents logged as pressure ulcers with 63% (139) recorded as grade two, 12.3% (27) recorded as grade 3 and 4.1% (9) recorded as grade 4. The largest number of pressure ulcers were recorded in general medicine 49.0% (107) and care of the elderly 43.1% (94).
- There were 102 incidents logged as medication errors with 87% (89) resulting in no harm, 11.7% (12) low harm and 1% (1) moderate harm across medicine and the specialities.
- Incidents were reported via an online reporting system (datix); staff confirmed that they knew how to use the online reporting system. Staff said they would report medication errors or patients with pressure ulcers, however several staff told us they would inform their manager rather than report. For example, staff would inform their manager if agency staff did not turn up rather than report it.
- Staff told us that they had little feedback from incidents but if they reported an incident they would receive an email confirming that the incident had been logged.
- Mortality and Morbidity review meetings were speciality led; we reviewed 13 mortality and morbidity minutes. We saw that patient deaths were reviewed however action points or lessons learnt were not always identified. For example, reference was made to documentation ("10 points about me") not being in place; however this was not identified as a learning point. A problem was also highlighted with the medical

Medical care (including older people's care)

on call data base which prevented a review of tasks that were undertaken as these were automatically deleted and in one speciality it was recorded that lack of case notes prevented discussions. This meant that patient's death had not been reviewed. Not all the junior doctors we spoke with had attended mortality and morbidity meetings, not all the minutes of the meetings recorded who attended.

Duty of Candour

- From November 2014, NHS providers are required to comply with the duty of candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The duty of candour is a regulatory duty that rates openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Senior staff had been trained in the duty of candour and the trust policy was available online for all staff. Clinical governance minutes demonstrated that compliance with duty of candour was followed when responding to patients and/or their relatives when investigating incidents.
- Most staff were aware of their responsibilities under duty of candour, which ensured patients and/or their relatives were informed of incidents that had affected their care and treatment and they were given an apology. However, some ward staff were unfamiliar with the term duty of candour but most were able to describe the need to be honest and open with patients and their families about mistakes.

Safety thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs), falls with harm to patients over 70 and Venous Thromboembolism (VTE) incidence. Safety thermometer data detailed below covers the six month period from April 2016 to September 2016.
- Safety thermometer performance data was displayed on the safety noticeboards at most of the ward entrances. This meant patients and their visitors could easily identify how well the ward was performing.

- There were 21 new pressure ulcers across the medical wards recorded by the safety thermometer, 19 were recorded as graded 2 and two were grade as 4. The worst performing wards were Tower ward 7 and Charles Coward ward with six and five new pressure ulcers respectively. We saw evidence that the SSKIN care bundles or 'Waterlow Pressure Ulcer Prevention Score' were used across the medical wards however we found that these were not consistently completed. We saw evidence that pressure relieving mattresses were in use however some mattresses were not switched on.
- There were 25 falls across the medical wards recorded by the safety thermometer, 17 were recorded as no harm and two were low harm. The worst performing wards were Charles Coward ward and Tower ward 7 with seven and four falls respectively. We saw evidence that risk assessments had been mostly completed and reviewed.
- A total of 24 catheter related UTIs were recorded via the safety thermometer. The majority (9) of these occurred on Tower ward 8. A urinary catheter site inspection sheet was used to encourage staff to review whether the catheter was still required. We saw these forms were in place and completed for most patients with urinary catheters however they were not consistently completed on a daily basis.

Cleanliness, infection control and hygiene

- We looked at the results of the patient led assessments of the care environment (PLACE) 2015. The trust scored 95% for cleanliness which was similar to the England average 98%.
- All the wards we visited were visibly clean. We observed support staff cleaning throughout the day. Wards had daily cleaning schedules in place, which staff would tick to indicate when specific areas had been cleaned. We saw the daily clinical and environmental logs were completed.
- On the wards we observed green 'I am clean' labels were in use to indicate when equipment had been cleaned. However, in the endoscopy unit none of the equipment had stickers on them to indicate they had been cleaned. Storage space was limited and equipment was stored in treatment areas, waiting areas and in administrative offices. It was not possible to identify which equipment had been cleaned and decontaminated ready for use.

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- The trust reported no incidents of Methicillin-resistant staphylococcus aureus (MRSA), 40 cases of incidents of Clostridium Difficile (C Diff) and five cases of Methicillin sensitive staphylococcus aureus (MSSA) for the period June 2015 to May 2016. 19 of the reported C Diff cases related to then medicine and medical speciality wards; we saw no evidence of these being followed up in the clinical governance meeting.
- Hand gel was available for use at the entrance to the wards/clinical areas, within the wards at the entrance to bays and side rooms. The trust undertook weekly hand hygiene audits which showed for the period January 2016 to March 2016 all but one of the general medical and medical speciality wards scored between 87% and 100% compliance with Podium ward 1 scoring between 62% and 88%. However, on the wards we observed that staff did not always wash their hands between patients.
- Adequate supplies of personal protective equipment (PPE) were available and we saw staff using this when delivering care. However, on wards we observed that staff did not always wear gloves or aprons when for example they had been changing an incontinent patient on a ward. We also observed a medic insert an IV cannula without wearing gloves. We noted staff adhered to the "bare below the elbows" trust policy in clinical areas.
- On one ward we observed that three catheter bags were touching the floor one of which was leaking. This was raised with nursing staff who changed the bag and cleaned the floor.
- Side rooms were used to care for patients where a potential infection risk was identified. This was to protect other patients from the risk of infection. Signs were in place at the entrance to side rooms which were being used for isolating patients, giving clear information on the precautions to be taken when entering the room. However, we observed a member of staff (T7) not removing or changing their apron after leaving a patient who was in isolation when serving their lunch time meal.
- On the wards we observed clinical and domestic waste was appropriately segregated and there were arrangements for the separation and handling of high risk used linen. We observed staff complied with these arrangements.
- We observed sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw sharps containers were used and they were dated and signed when brought into use. However, we observed on one ward (Charles Coward) a sharps box was left open with the needles in view, it was full and unattended.
- On the endoscopy unit, we observed a doctor and nurse escort a patient into a procedure room that had not been cleaned after the previous patient. In this room, a partially-used bag of fluid as well as a supply of adrenaline and midazolam (drugs used for anaesthesia) from a previous patient was left out and not cleared away when the next patient arrived. We asked staff in the room about this. They said the drugs should have been disposed of but they had forgotten to do this.
- A chair in the recovery area had a large tear in the arm and had been poorly repaired with tape, which was itself damaged. The foam was visible and was dusty. This presented a significant infection control risk to patients as it could not be cleaned effectively.
- In endoscopy decontamination nurses followed JAG best practice guidance in maintaining scopes and endoscopic equipment. We looked at the decontamination logs for this equipment and found them to be double-checked and accurate. Staff used a 'buddy checklist' system to ensure cleaning and decontamination procedures tracked individual items of equipment for audit and safety purposes.
- Infection prevention and control level 2 training formed part of the mandatory training programme and was updated annually. The trusts target was 90% of staff having completed the training. Within medicine and the medicine specialities 70% of medical staff, 74.2% of nursing staff and 92.3% of allied health professionals had completed the training. Compliance with Infection prevention and control training was below the trusts target for medical and nursing staff.

Environment and equipment

- We looked at the results of the patient led assessments of the care environment (PLACE) 2015. The trust scored 87% for facilities which was similar to the England average 88%.
- The trust has purchased pressure reducing hybrid systems which allow the mattress to be either static or dynamic when attached to a pump. We observed that some mattresses did not appear to be on as there were no lights on the control panels. Nursing staff we spoke with did not know about the settings for the pressure relieving mattress. They were unable to tell us tell us

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how they set them up and staff showed no understanding of what the warning lights meant. Nursing staff said “we get them (pumps) out of the cupboard and switch on”. Another nurse told us they “look at a patient and if they seem heavier set high”. The mattresses were on various high and low settings but we could not find any evidence why patients were on particular settings. For example, a patient (diabetic, at high risk of a pressure ulcer) weighting 54 kg was on a high setting when should have been low according to instructions.

- We observed ward bays and corridors were generally kept clear of equipment, therefore avoiding trip hazards so people were kept safe.
- On the wards we found the utility areas were generally clean and locked. However, on T5 we found that the waste disposal room was unlocked and readily accessible, with a full sharps bin on the floor. This did not comply with requirements about the safe storage of hazardous material. The sluice room was unlocked and readily accessible, with chemical tablets on display.
- The wards in the tower block were bright and airy, with bays colour coded. There was signage to help patients identify male/female bathrooms, toilets and shower rooms.
- One of the care of the elderly wards (Pymmes Zero, the patients had had been relocated to T4) was closed and being refurbished so that it became a dementia friendly ward. On one of the other of the care of the elderly wards (Charles Coward) the environment of the day room had been made more dementia friendly. On all the care of the elderly wards we saw that there was signage to help patients identify male/female bathrooms, toilets and shower rooms.
- We found each clinical area had resuscitation equipment stored on resuscitation trolleys, readily available and located in a central position, however they were covered in plastic sheeting. Staff advised this was to prevent the trolleys getting dusty. We saw that the resuscitation trolleys were checked daily. The trust had introduced a new policy that states trolleys are checked daily in ‘clinics’ and twice daily on wards and theatres by checking the numbered seal is still in place. Once a month they should break the seal and check each item and re-seal with a new numbered seal, also on each occasion of use. We saw that this was being followed on the wards.

- On T8 we observed that the kitchen door was propped open by a bin, despite a notice saying kitchen door to be kept shut for fire safety.
- We saw that all Electrical Medical Equipment (EME) had a registration label affixed and was maintained and serviced in accordance with manufacturer’s recommendations. We also saw Portable Appliance Testing (PAT) labels were attached to electrical systems showing they had been inspected and were safe to use.
- Health, safety and welfare training formed part of the mandatory training programme and was updated annually. The trusts target was 90% of staff having completed the training. Within medicine and the medicine specialities 77.5% of medical staff, 91.8% of nursing staff and 98.9% of allied health professionals had completed the training. Compliance with health safety and welfare was below the trusts target for medical staff.

Endoscopy

- The trust told us that the head of medical equipment management unit and associate director for infection prevention and control performed the role of authorised person (AP) and competent person (CP) for endoscopes. This is an individual professionally trained and qualified to ensure all endoscope machines are tested and commissioned to Health Technical Memorandum HTM 01-01: Decontamination of Reusable Medical Devices.
- On the endoscopy unit, we found significant problems with the cleanliness and upkeep of the environment. Several surfaces in treatment areas and waiting rooms were visibly dusty and dirty. A cupboard used to store endoscopic scopes had a half-inch layer of dust in the base. We asked a nurse about this. They told us it was the responsibility of the cleaning contractor to ensure all areas were cleaned but this regularly fell short and so nurses had to also spend time cleaning. A member of cleaning staff was on duty during our inspection but we could not locate them to ask about the dusty areas. A sluice area that was unlocked and easily accessible contained ten packages of chlorine tablets. This represented a risk of poisoning and this material should have been stored securely.
- The drying room in endoscopy was cluttered with pillows, boxes of sheets, a set of dirty ladders and several metal shelves that were stored there. Many surfaces in this area were dusty and dirty but we observed decontamination staff preparing clean

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endoscopic equipment ready for use in this room. A washer in the room had a previous electrical fault and staff told us boxes stacked against an electrical socket were there to "stop people using the sockets." There were no posted signs or 'caution' tape to ensure everyone who had access to this room understood the risks. This room contained a hazardous material spill kit, which is used to contain dangerous chemical spills from the washing equipment. A sign on the wall above the kit stated 'Do Not Obstruct'. However, the kit was not readily accessible and had boxes and other equipment on top of it. Staff working in the area could not explain why this was the case and told us they had not been trained in the use of the spill kit. They were also unable to explain in what circumstances they would use it. This meant there was a risk that a serious chemical spillage would not be dealt with rapidly or safely. This was brought to the attention of the trust and took appropriate corrective action.

- A trolley used to store disposables for endoscopic procedures was in the accessible corridor in the unit and was not supervised by staff. This included sterile water for irrigation, sodium chloride fluid, spray nozzles and lignocaine gel.
- We spoke with a member of staff about the environment and infection control. They said all of the staff were aware of the problems in keeping the environment clean and safe. They said they had taken photographs and sent them to the cleaning contractor's management team to show them cleaning standards needed to be improved. No action had been taken following this.
- The mobile endoscopy unit was clean and well maintained. Documented evidence of daily cleaning was available and all equipment was clearly labelled as clean and ready for use.

Medicines

- We found that generally medicines were stored securely and appropriately, including those requiring refrigeration. Regular expiry date checks were in place and there were suitable arrangements for ensuring medicines were available out of hours. However, a fluid store on one ward (Charles Coward) was not locked and the treatment room door on one ward was left open on two occasions when we were present (AMU), and found that pre prepared medicines to take away (TTA) and potassium were not stored in locked cupboards. We saw

that new locks had been ordered. We also noted that during the medicines round nurses were sharing a set of keys which were also used by the doctor, which made maintaining security more difficult (Charles Coward)

- Controlled drugs (CDs) were stored and managed appropriately. The CDs were checked twice a day by two registered nurses.
- A pharmacist visited the ward and carried out medicines reconciliation on all new patients Monday to Friday. Medicines reconciliation is the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency and route, by comparing the medical record to an external list of medications obtained from a patient, or GP.
- On the wards we observed pharmacists speaking to patients about their medications, and any changes. Pharmacists also ensured that when patients were discharged that patient's GP and community pharmacists were aware of any changes via email.
- A recent audit of waiting times for discharge medicines had shown that in June 2016 the target time of two hours had been met 67% of the time. Staff we spoke with suggested that this was improving currently. To facilitate this, two independent pharmacist prescribers worked on the wards and prescribed medicines for discharge. We saw that the multidisciplinary meetings discussing discharges included information from the pharmacist and plans for discharge medicines.
- To enable some patients to be discharged more efficiently small packs of common medicines were pre-labelled and stored on the wards. Two nurses, who had been specifically trained to do so, dispensed these medicines and checked the accuracy. The prescriptions were signed by both nurses and a record was made in the too take out (TTO) log.
- Prescriptions were written clearly and included the patients' allergy status. Antibiotics were automatically reviewed every five days and an antibiotic policy was followed.
- We saw that where medicines had not been administered a code was entered on the chart. We did not see any that referred to medicines not being available. The pharmacy department recently had a 'medication awareness week' and promoted a zero tolerance of omitted doses. This followed an audit in July 2016 that had shown 8.9% of omitted doses were

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recorded as 'medicine not available'. Nursing staff we spoke with were aware of how to obtain medicines if they were not immediately available and told us how the stock lists for some wards had been updated.

- We observed nurses giving medicines to patients. They wore aprons to show that they were not to be disturbed and spent time ensuring that their patients took their medicines safely. We found that the 8am medicines were generally given by night staff before they went off duty at 7.30am. Nursing staff told us that on occasions they administered medication that another nurse has signed for if the patient had not taken their medicine before they went off duty and we observed nursing staff completing drugs charts after it had been pointed out they had not completed them. This meant that patients were at risk of not being administered their medication as prescribed.
- On one ward (Charles Coward) we saw that IV fluids were not always entered on to prescription charts with details of the batch numbers or the time they were put up. We saw that a syringe with clear fluid and needle attached had been left unattended in a bay with four patients, two of whom had been identified as a risk, had dementia and wandered. We also found three tablets on the floor beside a patient's bed this was brought to the attention of nursing staff who advised that agency staff had been on at night.

Records

- Medicine and the medicine specialities had integrated patient records shared by doctors, nurses and other healthcare professionals. This meant all professionals involved in a patient's care could see their full record and recorded information in chronological order in the clinical notes section. This section included the medical plan for the patient. The clinical notes provided a description of the patient progress.
- Patients' medical notes (hard copies) were stored the wards. We found that these were generally not locked away but located near the nurse's station. However, on one ward (Charles Coward) we found that patient notes and prescription charts were on top of the reception desk, and on top of cupboards left out for anyone (patients, visitors) able to view them which meant patients records were not kept confidential or kept secure.
- Medical staff had access to electronic patient records (EPR), so they were able to order tests and look at

results and images. The computers were on trolleys based on the ward; this meant that the doctors were able to take the computer to the patients' bedside to refer to their results when in consultation. However, we observed that screens were not always locked when left unattended and we able to access confidential patient notes.

- On the endoscopy unit, we found a large quantity of confidential patient files and notes stacked on office desks in rooms that were not locked or secured. There was a file containing lists of patient names and mobile phone numbers left on a trolley in an unsecured corridor and a book containing the details of all patient procedures carried out was stored in this corridor on the top of a trolley. Staff moved this to a secure location after we asked why it had been left out in an accessible area.
- We looked at 19 sets of patient records. The records showed most patients had been seen on a within 12 hours of admission. Diagnosis and management plans were identified, nursing assessments and care plans were mostly incomplete. Risk assessments had been mostly completed and reviewed. These included pressure ulcer risk assessments, Venous Thromboembolism (VTE), nutritional and falls risk assessments.
- On one ward (T8) patients had bed rails in place. We looked at the bed rail assessments and found four that were not completed. Bed rails restricted a patient's ability to get out of bed, we found no evidence of a mental capacity assessment or a deprivation of liberty safeguards (DoLS) was in place for those patients to suggest they did not have capacity.
- We looked at patient bedside notes and found these were not always completed consistently; these included repositioning charts, food and fluid charts, waterlow and observations. We found that SSKIN bundles were usually commenced on admission, but frequency of intervention was not always recorded which meant that positional changes happened inconsistently between two to four hours. SSKIN bundles showed that staff were recording 'R' for redness however there was no evidence that the care to patients had been increased.
- The trust has purchased pressure reducing hybrid systems which allow the mattress to be either static or dynamic when attached to a pump. Within the SSKIN bundle the staff either record DF = foam (static) or DP = pump (dynamic). In patients records we saw that the

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skin bundles inconsistently recorded both DF and DP. Recorded in a patient's record was evidence of hospital acquired pressure damage (grade 2) to the patient's heel and sacrum. The patient's bed had a pump attached but it was not switched on. No incident forms had been completed; this was escalated to ward manager.

- On the care of the elderly wards documentation called '10 things about me' should have been completed within 24 hours of a patient being admitted onto the wards; however we found little evidence of this being in place. We also found that body maps were not completed on admission to the wards which meant the state of patient's skin on admission to wards was not known.
- Matrons undertook weekly documentation audits as part of the 'back to the floor' initiative that had been recently introduced across the trust.
- Information governance formed part of the mandatory training programme and was updated annually. The trust's target was 90% of staff having completed the training. Within medicine and the medicine specialities 68.6% of medical staff, 77.6% of nursing staff and 94.9% of allied health professionals had completed the training. Compliance with information governance training was below the trust's target for medical and nursing staff.

Safeguarding

- Staff had access to the trust's safeguarding policy via the trust intranet and knew how to access the safeguarding team for advice and guidance when required. However, not all staff were aware who the safeguarding lead was.
- Staff were able to identify the potential signs of abuse and the process for raising concerns. Some staff told us that they would report any concerns to the nurse in charge or make a referral to the safeguarding team. We were given examples of concerns they had identified and referrals made. Staff told us they occasionally received feedback on the outcome of referrals.
- Safeguarding adults and safeguarding children's level 1 and level 2 training formed part of the mandatory training programme and was updated three yearly. The trust's target was 90% of staff having completed the training. Within medicine and the medicine specialities 78.3% of medical staff had completed safeguarding adults training and safeguarding children training, 69.6% of nursing staff had completed safeguarding adults training and 89.5% had completed safeguarding

children's training and 94.2% of allied health professionals completed safeguarding adults training and 89.4% had completed safeguarding children's training. Compliance with safeguarding adults training was below the trust's target for medical and nursing staff and compliance with safeguarding children's training was below the trust's target for medical, nursing and allied health professional staff.

Mandatory training

- Staff were aware of the mandatory training they were required to undertake.
- The mandatory and statutory training programme covered conflict resolution, equality, diversity and human rights, fire safety, health safety and welfare, infection prevention and control levels one and two, information governance, moving and handling levels one and two, adult basic life support levels 1 and 2, safeguarding adults levels 1 and 2, safeguarding children levels 1 and 2.
- Ward managers we spoke with demonstrated the systems they used locally to monitor their staff attendance at mandatory training to ensure it was completed, or refreshed.
- The trust's target for staff having completed their mandatory and statutory training was 90%. At the time of our inspection, compliance with mandatory training for medicine and the medicine specialities was 71.6% for medical staff, 83% for nursing staff and 92.3% for allied health professionals. Compliance with mandatory training was below the trust's target for medical and nursing staff.

Assessing and responding to patient risk

- Patients' clinical observations such as pulse, oxygen levels, blood pressure and temperature were monitored in line with NICE guidance CG50 'Acutely Ill-Patients in Hospital.' A scoring system known as the national early warning score (NEWS) was used so staff were able to recognise "at risk" patients and to trigger early referral to medical staff, for early intervention to help prevent deterioration. We looked at eight NEWS charts and found that these had been scored correctly and acted upon if necessary.

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- There was a clinical protocol in place for managing and responding to acutely unwell patients. Staff knew if a patient scored 5 or more to inform the nurse in charge or the critical care outreach team (CCOT). Staff told us that they found the support from the CCOT helpful.
- The use of early warning systems was audited across the wards in February and March 2016 over one day looking at five patients records on each ward. The audits highlighted the lack of accuracy of the news score and further staff training and support was identified.
- Patients were risk assessed in key safety areas using nationally validated tools. For example, we saw the risk of falls was assessed and the risk of pressure damage was assessed using the Waterlow score. We observed risks were always updated with appropriate risk management actions.
- Adult basic life support level 1 and 2 formed part of the mandatory training programme and was updated annually. The trusts target was 90% of staff having completed the training. Within medicine and the medicine specialities 69.4% of medical staff, 76.9% of nursing staff and 83.9% of allied health professionals had completed the training. Compliance with adult basic life support training was below the trusts target for medical, nursing and allied health professional staff.

Nursing staffing

- The vacancy rate across all the medical specialities as of 12 July 2016 for nursing staff was 39.72 whole time equivalents (WTE). Wards we visited had various levels of nursing vacancies, the highest being on Tower ward 7 (4.47 WTE), AAU (4.02 WTE), Tower ward 6 (3.94 WTE), Pymmes Zero (3.53 WTE), AMU (3.44 WTE), Michael Bates ward (3.13 WTE) and Endoscopy (5.79 WTE). The other wards Tower wards 8 and 5, Charles Coward ward and the day hospital had less than 3 WTE vacancies. Staff told us they were frequently short of staff on the wards and on some wards agency staff were used on a daily basis. Ward managers advised that they had difficulty in recruiting health care assistants (HCAs).
- The ward manager told us that when bank or agency staff were used to cover shifts they would try to use the same staff. We saw that bank and agency staff had local induction and orientation sheets so that they could familiarise themselves with the ward quickly.
- Across medicine we found that the use of agency and bank nursing staff differed across the medical specialities for the period August 2015 to July 2016. The average being 23% on Pymmes Zero, Tower ward 7 and the day hospital 22% and the other wards used and average of between 9% and 18%.
- Ward managers would inform the site practitioners if staff levels or the skills mix were not as planned. Ward managers reported staff would be moved to different wards within the medical specialties to ensure safe staffing levels were maintained or bank or agency staff would be utilised if approved. We saw that one ward (T8) was two HCAs short and this had been escalated to the duty manager who was looking for additional cover.
- The numbers of staff planned and actually on duty were displayed at ward entrance in line with guidance contained in the Department of Health Document 'Hard Choices'. On the wards we visited we observed staffing levels were generally in line with planned staffing levels. Nurses were generally allocated to bays. Staffing levels were determined using an acuity tool to determine safe staffing levels which had been reviewed in October 2015. Wards were staffed on 1:7 nurses to patient ratio during the day with assistance from an allocated nursing assistant and these would be reduced at night to 1:8. Ward matrons were supernumerary to the agreed staffing levels so that if required, they could support ward staff if patient acuity or occupancy increased. A ward manager advised that staffing levels had been reduced in July 2016 which meant staff had less time to spend with patients. Staff that provided one to one support for patients (specials) were not counted in the staffing levels.
- On one ward staff told us on occasions there were two nurses looking after 22 patients at night. We saw that staffing levels had been identified as a risk and was on the clinical business unit's (CBU) risk register. The risk register noted that there had been two nurses to 29 patients on wards. This had been scored as a nine and categorised as 'tolerate' which meant no action would be taken to address this risk.
- Health care assistants were specifically trained as 'specials' to support patients who had complex needs. Staff told us that if patients needed one to one support this would be arranged by the ward manager. On T8 we saw that a patient who was at risk of absconding had one to one support at night however we could find no

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evidence of a deprivation of liberties safeguarding application (DoLS) or mental capacity assessment in place. The patient's previous DoLS application had expired.

- We observed three staff handovers, which started with a safety huddle to hand over key patient risks such as falls, pressure sores, and NEWS scores. This was followed by handover where nursing staff would take the hand over from the staff member who had been in charge of the bay. Staff had printed hand over notes, which they updated during the handover. Staff we spoke with told us that they had daily safety huddles at beginning and end of each shift. However, staff raised concerns about the information that was communicated at handovers. For example, patients with pressure sores or not eating were not always handover and they were not always followed up. This meant the patients' continuity of care was compromised as patients were not always looked after by the same nurses.
- In the endoscopy unit a team of registered nurses, decontamination nurses and healthcare assistants provided care. The unit was fully staffed with no nursing vacancies and each clinic list and treatment room operated with a defined number of staff. This included the mobile endoscopy unit, which was led by a theatre practitioner from the company that supplied the unit along with the trust endoscopy nurses. The lead nurse conducted a daily safety briefing and checked staff was up to date in their clinical competencies before allocating staff to specific areas.

Medical staffing

- Medical staffing comprised of consultants, specialist registrars, and senior house officers (SHOs) and foundation level doctors.
- There was consultant cover seven days per week in the AMU and AAU supported by foundation level doctors. On the medical wards consultants were available from 9am to 5pm Monday to Friday. At weekends an on call consultant was on site from 9am to 8pm to see new admissions and seriously ill patients. Out of hours cover was provided from 8pm to 9am by the on call consultant.
- At night the medical wards were supported by the night doctor team from 5pm to 9am Monday to Friday. At weekends a registrar, two SHO's and two foundation year doctors were available for the medical wards from

9am to 9pm and two SHO's and two registrars from 9pm to 9am with access to the on call consultant. Doctors we spoke with advised that at times there were not enough doctors on the wards and there were gaps in the rota.

- All medical wards had a daily consultant ward rounds Monday to Friday with junior doctor ward teams working alongside the specialist teams, however in the AMU/AAU the ward rounds were daily seven days per week
- We observed three consultant led multidisciplinary team (MDT) meetings and found they were carried out efficiently and effectively, with the appropriate staff present.
- Professional development for foundation doctors and registrar level doctors was timetabled. Doctors advised this had been recently increased and was training time was protected.
- Treatment in the endoscopy unit was led by a permanent consultant, with support from locum doctors. The leadership team had submitted a business case to the trust to secure funding for additional permanent consultants.

Major incident awareness and training

- There was a trust-wide major incident policy that was available to all staff via the hospital intranet and we noted many wards also had printed copies available at the nursing stations
- Fire safety formed part of the mandatory training programme and was updated annually. The trust's target was 90% of staff having completed the training. Within medicine and the medicine specialities 70.4% of medical staff, 77.5% of nursing staff and 97.9% of allied health professionals had completed the training. Compliance with fire safety training was below the trusts target for medical and nursing staff.

Are medical care services effective?

Requires improvement 

We rated effective as requires improvement because:

- The average length of stay was longer (6.1 days) than the England average (3.9 days) for elective care between March 2015 and February 2016.

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- Although out of hours cover was provided by an on-call consultant, at weekends a consultant was only available on site from 9am to 8pm to see new admissions and seriously ill patients.
- Food and fluid charts were in place for patients who required monitoring, however we found that staff had not always completed these charts appropriately and accurately which could affect patients care and treatment. Feeder cups and meals were not always left within easy reach of patients.
- Staff knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards was variable. Mental Capacity Act 2005 (MCA) and DoLS training was not part of the trust's mandatory and statutory training programme. We saw that patient's Deprivation of Liberties Safeguards (DoLS) applications had expired and patients were still subject to restraint. Staff did not always ask patients permission before care or treatment was given.
- The trust participated in national audits which showed the trust's performance was below the national averages of outcomes for patients compared with the national average. These included the Sentinel Stroke National Audit Programme (SSNAP), the Myocardial Ischemia National Audit Project (MINAP), and the National Diabetes Inpatient Audit (NaDIA). These outcomes were not being addressed effectively at the time of the inspection.

However:

- Multidisciplinary team (MDT) working was evident on medical wards. There was evidence of an MDT approach to discharge planning. Patients had access to the full range of allied health professionals such as speech and language therapists, dietitians, tissue viability, and diabetic nurses.
- Endoscopy, diagnostic services including imaging, physiotherapists and occupational therapists and pharmacy services and laboratory were available seven days per week.
- Most staff had received an appraisal. The trust reported 84.5% of nursing staff within the medical services had received an appraisal. This was above the trust target of 80%.

Evidence-based care and treatment

- The wards provided care in line with National Institute of Health and Care Excellence (NICE) Guideline - CG50 -

that covers recognising and responding to deteriorating patients. Staff used a national early warning score (NEWS) to identify deteriorating patients so they were escalated to the medical team or critical care outreach team (CCOT) appropriately.

- Staff were generally aware of the National Institute for Health and Care Excellence (NICE) guidance in relation to their speciality. Staff reported the clinical policies and guidance were available on the trust intranet and we saw staff were able to access these easily. However, we found that not all junior doctors were aware of the NICE Guidance that related to areas outside their specialities.
- There was a medical audit programme for 2015/2016, across the medical and the medicine specialties 22 national audits had been identified; and 12 audits had been identified as being undertaken, the remaining ten audits had been identified as not participating. Information provided by the trust showed that there were no local audits currently being undertaken. This demonstrates the trust was engaged in audits looking at the effectiveness of care.
- The endoscopy unit was 'Joint Advisory Group' (JAG) accredited at the time of our inspection. The unit was last accessed by JAG in December 2009.

Pain relief

- Patients were asked about their pain during patient comfort rounds. We saw that this was recorded on the patient comfort round record.
- Patients we spoke with told us they were comfortable. Staff asked patients about their pain levels and pain relief was administered in a timely way. The patient prescriptions we reviewed indicated that medicines were appropriately prescribed for pain relief as required.

Nutrition and hydration

- We looked at the results of the patient led assessments of the care environment (PLACE) 2015. The trust scored 87% for food which was similar to the England average 88%.
- Patients' nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST) as recommended by the British Association for Parenteral and Enteral Nutrition.
- We saw that scores were not recorded consistently. Food and fluid charts were in place for patients who required monitoring, however we found that staff had not always completed these charts appropriately and

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accurately which could affect patients care and treatment. Food and fluid charts are a valuable source of information regarding patients' health for doctors reviewing patients.

- We spoke with catering staff on the wards who told us that they were given daily lists of patients' dietary needs and any restrictions.
- Patients selected their food choices from prepared menus that provided a choice of foods. The menus had been designed to include a range of special diets, high energy, soft, gluten free, high fiber, vegetarian, halal and healthy eating options. However a patient told us "Food is often served too cold and is tasteless, and portions are too small. For example the beef casserole just has two or three pieces of meat".
- Patients were reviewed by a dietician if there were concerns with their weight or food intake. Dietary supplements such as fortified milkshakes were given to patients who needed a higher calorie intake. Patients were also referred to speech and language therapists if they needed assistance with eating and drinking.
- Drinks were mostly left within reach. However, relatives advised that water was not always available and we observed that feeder cups were not always within easy reach.
- All the wards operated a protected meal time policy. A relative advised that they wanted to support a patient at meal times but was told that they had to get permission; however when they arrived at visiting time they found the patient had not eaten. Another relative advised that meals and drinks were left on table when a patient had been initially admitted as staff were not aware that the patient was visually impaired. On one ward (Michael Bates) we observed four meals had been left uncovered out of the patient reach, none of the meals had been eaten.
- We saw there were adequate arrangements to ensure food safety. For example, we found food service personnel wore suitable personal protective equipment (PPE), food and fridge temperatures were checked and the temperature of food was checked before service to ensure it had reached safe temperatures. However, on one ward (T7) we observed a staff member did not remove the protective apron after giving a patient who was in isolation their meal.

Patient outcomes

- The trust participated in the Sentinel Stroke National Audit Programme (SSNAP), which is an on-going national audit that investigates and analyses the quality of care in stroke services. Hospitals are awarded a score A to E where A is the best. At North Middlesex University Hospital the stroke services scored a B rating in two quarters from April to September 2015 and D rating in two quarters from October to March 2016. This indicated the hospital was achieving variable outcomes for patients with strokes compared with the national average. We saw that the trust had an action plan in place which was being reviewed, updated and that some actions had been completed.
- The trust participated in the Myocardial Ischemia National Audit Project (MINAP), which is a national clinical audit of the management of heart attack. In 2013/14 the hospital scored comparable to the England average in two of the three standards audited for care of patients with non-ST-elevation infraction (nSTEMI). However, only 2.5% of patients had been admitted to the cardiac unit or ward compared to England average of 55.6%. We saw that the trust had an action plan in place to address performance where the trust was below the national average.
- In the National Diabetes Inpatient Audit (NaDIA) September 2015, the trust's performance was monitored against 18 indicators. In ten indicators the trust was in the lower England quartile and for eight indicators the trust was in the middle quartile. For example:
 - 53.9 % of patients experienced medication errors compared with 37.4% nationally.
 - 38.2% of patients had prescription errors compared with 20.8% nationally.
 - 36.8% of patients experience management errors compared with 22.6% nationally.
 - 31.6% of patients had insulin errors compared with 22.6% nationally.
 - 8% of patients had a foot risk assessments within 24 hours compared to 28.7% nationally
 - 1.1% of patients had a foot risk assessment after 24 hours compared to 5.4% nationally.
- We saw that the trust had an action plan in place which was due to be completed in December 2016 to address performance where the trust was below the national average.
- The trust participated in the 2014/15 National Heart Failure Audit and scored higher than the England

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average in all three of the four standards audited for clinical practice for in-hospital care. The hospital scored better than the England average in clinical practice for discharge in all of the seven standards audited.

- The trust participated in the 2014 National Lung Cancer Audit which showed that 100% (90) of patients had received a CT scan before a bronchoscopy and that 98% of the patients were discussed at a multidisciplinary team meeting. The trust participated in the 2015 audit; however information from the trust states the lung cancer audit data was not submitted.
- Between February 2015 and January 2016 the overall standardised risk of re-admission for medicine and the medicine specialties was similar to the England average for both elective and non-elective admission. However, for elective admissions gastroenterology and clinical haematology had more readmissions than the England average and for non-elective readmissions older person's medicine and clinical haematology had more readmissions than the England average. This means there were more readmissions than expected.

Competent staff

- Nursing staff told us that they attended a trust induction programme.
- All permanent and agency staff working on the unit for the first time were given a general induction to their working environment however it was unclear if the induction would be repeated if the agency staff member did not work on the ward for a period of time.
- New nurses underwent a preceptorship programme to accelerate their learning and development during the first few months of their job. New nurses undertook a series of competencies which they had to complete during the preceptorship period. The clinical practice educator or the relevant mentor signed off competencies; nurses also attended the trust's preceptorship programme and had preceptorship days outside the ward.
- We saw that clinical practice educators were available on some areas of the medical wards but not others.
- On wards nursing staff had link nurse functions; for example, nurses were responsible for infection control, falls, dementia, and discharge.
- Nurses told us there were opportunities for learning and development and they felt supported by the managers and colleagues.

- Staff undertook mandatory training as well as training relevant to their speciality. Mandatory training records highlighted that not all nursing staff had completed training in for example safeguarding adults, infection control and basic life support. As part of the trust's dementia strategy 100% of all front line staff were to have basic dementia awareness training. Information provided by the trust showed that 62% of nursing staff within medicine and medicine specialities had undertaken the training.
- We saw there was a range of clinical specialist nurses to provide advice and guidance on the care of specific groups of patients, such as those with diabetes and tissue viability issues. There were also lead specialist nurses for safeguarding.
- Staff told us they participated in the appraisal process. We reviewed documentation on wards and found most wards had some staff appraisals outstanding. The trust reported 84.5% of nursing staff within the medical services had received an appraisal. This was above the trust target of 80%. Most of the medical and specialist medicine wards met this target; however Pymmes Zero and Tower Ward 7 were the worst performing wards with 77.8% and 59.2% respectively.
- Doctors who commenced work at the hospital were required to undergo the generic hospital induction programme and then complete mandatory training modules. Junior doctors told us that they did get study leave if mandatory training had not been completed.
- The trust reported 86.00% of doctors within the medical services had received an appraisal which was above the trust target of 80%.

Multidisciplinary working

- We observed that multidisciplinary (MDT) working was evident on medical wards; physiotherapists and occupational therapists were part of ward board rounds. We saw that the multidisciplinary meetings discussed discharges included information from the pharmacist and plans for discharge medicines. We saw these were well attended and everyone's contribution was valued. There was evidence of a MDT approach to discharge planning.
- Ward and specialist medical teams had access to the full range of allied health professionals such as speech and language therapists, dietitians, tissue viability, and diabetic nurses. Where allied health professionals and specialist medical teams had been involved with

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patients they had recorded this in the patient records. A patient flow coordinator had recently been recruited to the Tower Wards to facilitate social care packages for patients on discharge. On the care of elderly wards a discharge nurse specialist coordinated social care discharges.

- The multidisciplinary records ensured there was good communication with input from each profession in the care of individual patients and care was co-ordinated for patients. We observed the healthcare team worked well together to provide care to patients. The acute stroke unit had a dietician, three physiotherapist and three occupational therapist based on the ward. However, we found in the day hospital (a ward where patients are admitted for a day and then discharged) which looked after mostly older people, the ward had speech and language therapists but there was no physiotherapy or occupational therapy input.
- Consultant led multidisciplinary board rounds called RAG (red, amber and green) meetings were held on a daily basis Monday to Friday. Patients care and treatment were reviewed with actions being taken being taken to progress care.
- The wards had access to psychiatric input and referred patients to the psychiatric services for assessment where there were concerns.

Seven-day services

- There was consultant cover seven days per week in the acute medical unit (AMU) and acute assessment unit (AAU). A consultant provided an on call service out of hours and at night after 5pm covering all the medical wards (9) Monday to Friday. At weekends the on call consultant was on site from 9am to 4pm to see new admissions and seriously ill patients. Out of hours was covered by the on call consultant.
- The medical wards at weekends were covered by a registrar, two SHO's and two foundation year doctors were available for the medical wards from 9am to 9pm. Two SHO's and a registrar were available to the wards from 9pm to 9am with access to the on call consultant.
- The endoscopy unit operated seven days a week, with up to eight clinics lists available daily including specialist colorectal procedures.

- Staff reported there was seven day availability of all diagnostic services including imaging, and laboratory facilities. They told us they did not encounter any problems with diagnostic services out of normal working hours.
- Physiotherapists and occupational therapists were available however speech and language services (SALT) provided a weekday only service.
- Pharmacy services were available at weekends with pharmacist visiting the wards.

Access to information

- Staff told us they received information from the trust and updates via email. However, staff told us that they did not access their emails regularly when on duty as they did not have the time when they were on the wards.
- Staff told us patient medical notes could be accessed quickly when needed. The ward clerks were responsible for locating and requesting medical notes.
- Patient investigation results were accessible electronically, including blood tests and imaging reports. Staff printed results off and placed them in the patient medical notes.
- Staff had access to national guidance on ward computers which could access internet sites. They told us this was invaluable for accessing NICE guidance and other key reference documents.
- To ensure continuity of care, staff working on the wards had detailed hand over sheets which they could refer to.
- Staff had access to an online learning management system and trust policies and protocols via the trust intranet.
- Staff names, roles and photos were on display on wards so that patients and visitors would know which staff worked regularly on the wards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- On one ward (T8) we saw that Deprivation of Liberties Safeguards (DoLS) applications had expired and patients were still subject to restraint. For example, a patient who was at risk of absconding had one to one support at night, or some patients had bed rails in place, in all cases we could find no evidence of a deprivation of liberties safeguarding application (DoLS) or mental capacity assessments in place. On another ward (T4) a patient was subject to a mechanical restraint by wearing

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mittens. The patient's records showed that the DoLS had expired. This meant that the patients had their liberty restricted without hospital staff being able to evidence that the patient did not have the capacity to agree to their treatment plans.

- Most staff were familiar with DoLS although not all staff could accurately describe what it entailed or the implication of DoLS in a hospital setting.
- Mental Capacity Act 2005 (MCA) and DoLS training was not part of the trust's mandatory and statutory training programme.
- Patients told us staff did not always ask their permission before care or treatment was given. We observed occasions when doctors did not always ask patients before they examined them and we also observed nursing staff did not speak to patients or gaining consent when giving personal care.

Are medical care services caring?

Requires improvement



We rated caring as requires improvement because:

- We spoke with 39 patients and their relatives about their experience. Feedback from relatives and patients we spoke with was mixed. The feedback from some patients indicated staff were not always providing compassionate care.
- Some patients were not treated with dignity and respect; we observed staff speaking unkindly and in a patronising way to patients.
- Nursing staff and doctors did not always introduce themselves or tell the patients what they were doing.

However:

- The trust used the Friends and Family Test (FFT) to gather patients' views on whether they would recommend the service to family and friends. Overall, these showed satisfaction with the service, with the medical wards ranging from 58% to 100% during the period June 2015 to May 2016.

Compassionate care

- We observed a number of interactions between patients and nursing staff where patient were not treated with dignity and respect, we observed staff speaking unkindly and in a patronising way to patients. For example:
 - We observed nursing staff not listen to a patient, the patient was asking for a pillow but was interrupted by the nurse who told the patient that they already had a pillow; eventually the patient was able to explain that they had a folded blanket and not a pillow.
 - We observed a nurse discussing a confused patient, they described the patient as "he is funny, he makes funny faces", which is not respectful.
 - We observed staff refuse to reposition a patient when they asked; they told the patient "no time".
 - We observed a patient had requested some ice cream, they were told there were none left; the staff member did not try to get some.
- On Charles Coward ward we undertook a 'SOFI' (Short Observational Framework for Inspection). SOFI is an observational tool used to help us collect evidence about the experience of people who use services, especially where people may not be able to fully describe these themselves because of cognitive or other problems. We observed three patients in one bay for 30 minutes, during that time we saw nursing staff and doctors did not always introduce themselves or tell the patients what they were doing, one patient was receiving personal care and there was no conversation.
- We spoke with 39 patients and their relatives about their experience. The feedback from patients was variable. For example:
 - Some patients told us they thought the staff were "pleasant", they were treated with dignity and respect, they were looked after well and staff were gentle when giving personal care. Patients also commented the consultants saw them every day and they listened to what they said. A relative told us that they thought staff gave "good care and don't know why people complain".
 - Some patients told us that some nurses were "very rough and uncaring"; they did not listen to what patients were telling them. A relative told us that staff had no understanding of their relative's hearing

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disability as staff would shout and walk away when the patient had not understood. Another relative told us that communication with nursing staff was difficult as English was not the nurse's first language.

- Patients also told us that call bells were not always answered in a timely way and that they would "shout for assistance" and that night time was worse. A patient told us "sometimes you have to wait, sometimes you have to call again, sometimes 10 -15 minutes then they come, you have to wait for the staff nurse".
- A patient also told us that they had asked for a commode but were given a bedpan which resulted in them being left in their own urine and it took a long time before staff came to assist them. When we spoke to them they were very upset about the experience.
- We looked at the results of the patient led assessments of the care environment (PLACE) 2015. The trust scored 80% for privacy, dignity and wellbeing which was worse than the England average 86%.
- The trust monitored patient experience across the wards. For the period January 2016 to June 2016 the wards scored between 96% and 100% for treating patients with dignity and respect when they were being examined and between 94% and 100% for being cared for.
- The trust used the Friends and Family Test (FFT) to gather patients' views on whether they would recommend the service to family and friends. We looked at the latest FFT scores available for the period June 2015 to May 2016. The average response rate for the medical wards was 20.7%. Overall, these showed satisfaction with the service, with the medical wards ranging from 58% to 100% during the period. The AMU and Tower 8 had the most consistent feedback scoring 100% in 10 of the 12 months; The AMU's response rate was also the highest at 35%.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they felt involved in their care and understood their treatment and care plans. Patients described conversations with the doctors and consultants, they had been able to ask questions and had been told how their illness or injury might improve or progress.

- Feedback from relatives was mixed. A relative we spoke with told us they did not feel involved in planning their father's discharge who had become unwell and was unable to return to his own home. They felt the hospital rushed it. They also felt doctors could have better managed how they had delivered bad news. In the day hospital a relative commented that they felt included and informed of their relatives care.
- During the SOFI on Charles Coward ward we observed a doctor and a nurse by a patients bed talk about the patient and they did not involve the patient in their conversation.
- The trust monitored patient experience across the wards. For the period January 2016 to June 2016 the wards scored between 76% and 99% for being given as much information about your condition or your treatment and between 78% and 99% for having their care and treatment explained by doctors and nurses.

Emotional support

- The hospital chaplaincy service provided services to patients across the hospital. Staff were aware of how to contact spiritual advisors to meet the spiritual needs of patients and their families. The chaplaincy service was available to staff as well as patients.
- On the wards notice boards we saw that patients were able to attend songs of praise every 2nd and 4th Friday.

Are medical care services responsive?

Requires improvement 

We rated responsive as requires improvement because:

- The trust had a dementia strategy, most of which had not been implemented. We found no evidence of activities such as cards, games or puzzles.
- We looked at 15 sets of patient records we found that nursing assessments and care plans had mostly incomplete. This meant that patients care needs were not all identified and that patient could be receiving care that was not appropriate to their needs.
- The percentage of patients that started consultant led treatment within 18 weeks was consistently lower than the England average of 90%.

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- The trust reported the total number of bed moves across the medical wards at night between the hours of 10pm and 6am was 315. The largest number of moves involved patients in general medicine 54.6% (172) and care of the elderly 16.5% (51).
- The average length of stay was longer (6.1 days) than the England average (3.9 days) for elective care between March 2015 and February 2016.
- Complaints were discussed at monthly clinical governance meetings. We saw that complaints were monitored and outcomes recorded with details of action points and learning identified.
- Staff we spoke with told us that they rarely had feedback about complaints or learning from them.
- Demand for medical beds frequently outstripped supply especially in the winter period. In these circumstances patients could be placed in additional beds outside of the speciality. There were arrangements to ensure that outlying patients were reviewed by speciality teams and nursing staff reported these arrangements worked well.
- To address increasing demand on the service, a mobile endoscopy unit provided additional capacity Monday to Friday. The mobile unit was staffed by trained endoscopy nurses from the main unit and clinical oversight was provided by a theatre practitioner

However:

- The day hospital admitted patients for the day so that they could undergo tests. Relatives either brought patients in or the hospital arranged for patients to come via the patient transport service.
- Staff in endoscopy had identified Turkish, French and Polish as the most commonly spoken languages other than English amongst their patients. To meet their needs, information leaflets about preparing for endoscopic procedures were available in these languages.

Service planning and delivery to meet the needs of local people

- Reviews of the inpatient processes were underway to make the patient journey more seamless and to ensure patient needs were met at all stages of receiving care.
- Patients were accommodated in single rooms or in single sex bays. Hospital data showed there were no mixed sex accommodation breaches on any of the medical wards over the last 12 months.
- Care of the elderly wards were seeking to improve the ward environment to make them more dementia friendly by becoming bright and airy, with each of the bays themed and colour coded. The trust was in the process of refurbishing Pymmes Zero.
- Visiting times were 2pm to 8pm every day. Relative we spoke with told us that they had to get permission from the wards to be able to support their relatives during meal times.
- We saw there was a discharge lounge where patients could wait for transport. Patients had access to food and hot and cold drinks.

Access and flow

- Four site management meetings took place each day (8.30am, 10.30am, 12.30pm, 3pm, 5pm) to discuss patient flow into and out of the hospital. Representatives from each ward as well as more senior hospital management such as clinical directors attended these meetings. Any available beds as well as patients who need admission, awaiting discharge or on outlying wards were identified. From this information, the site management team decided which patients should be admitted to each ward and supported the discharge of patients to make more beds available.
- Patients were often admitted to the medical wards after becoming unwell at home and attending the accident and emergency department at the hospital. Patients would either be admitted to the acute admissions unit for further tests and assessment if their stay was 24 hours or less. Staff told us patients should be resident on acute medical unit for a maximum of 72 hours as they should be admitted to a long stay ward after this. They told us the 72 hour period was frequently extended.
- The day hospital admitted patients for the day so that they could undergo tests. Relatives either brought patients in or the hospital arranged for patients to come via the patient transport service.
- Designated discharge nurses and a patient flow coordinator would oversee patients' discharge arrangements. This involved liaising with families, organising care packages and ensure that to take out (TTO) medicine had been ordered if required. Discharge plans were discussed at multidisciplinary team (MDT) board rounds.
- A discharge lounge was used to accommodate medically stable and independent patients while

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waiting for to take away (TTA) medicines or transport prior to their discharge home which was staffed by nursing staff. This allowed ward beds to become free more quickly.

- Bed moves were coordinated through the site control room. During the period June 2015 to May 2016, 67% (25,3697) of patients experienced no ward move, 27% (9,446) of patients were moved once, 5% (1,606) of patients were moved twice, 2% (787) patients were moved three times and 1% (521) patients were moved four or more times. This demonstrated 67% of patients were treated in the correct speciality bed for the entirety of their stay.
- The hospital at night team was responsible for patient movement overnight and was made up of two SHO's and two registrars from 9pm to 9am with access to the on call consultant.
- For the period January 2016 to June 2016 the trust reported the total number of bed moves across the medical wards at night between the hours of 10pm and 6am was 315. The largest number of moves involved patients in general medicine 54.6% (172) and care of the elderly 16.5% (51).
- The percentage of patients that started consultant led treatment within 18 weeks was consistently lower than the England average of 90% from August 2015 to March 2016. In April and May 2016 there was an improvement in performance when the trust performed better than other trusts.
- A service level agreement had been initiated between the endoscopy unit and similar services in London following a fire and another electrical fault in scope washing equipment. This ensured clinic lists were not cancelled or delayed but added additional pressure to staff in the management of a very busy service.

Meeting people's individual needs

- We looked at 15 sets of patient records we found that nursing assessments and care plans had mostly incomplete. This meant that patients care needs were not all identified and that patient could be receiving care that was not appropriate to their needs.
- Patients over the age of 75 years were screened for dementia within 72 hours of admission. Between April 2014 and March 2015, 90.4% of patients were being screen for dementia within 72 hours.

- On wards we saw that some patients had different colour wrist bands. These would be used to identify patients who were at risk of the following:
 - Yellow – the patient was at risk of falls.
 - Red – the patient needed assistance with eating or had a special diet.
 - Blue – the patient was living with dementia.
 - Pink – the patient was at risk of pressure ulcers.
 - Green – the patient had a catheter and the date of insertion was recorded on the wristband.
- All the medical wards were divided into bays which provided single sex accommodation with designated male and female facilities in the bays.
- One of the care of the elderly wards was in the process of being refurbished so that the ward became more dementia friendly; we saw that other care of the elderly wards had started to change the ward environment. For example, we saw that dementia friendly clocks were in bays on the wards, however we noted that the clocks had different date and times. We found no evidence of activities such as cards, games or puzzles.
- We observed staff providing one to one care (specials) were utilised on some of the medical wards. On the AMU we observed staff accompanying a patient who wanted to walk around the ward. This meant the patient was being monitored and kept safe from harm or risks such as risk of absconding.
- The medical wards operated a protected meal time policy.
- A variety of food was available to meet people's individual needs. This included special dietary needs such as gluten intolerance, Halal meat, kosher meals, Asian food and vegetarian options.
- Feedback for patients about the food was varied most patients told us that the was "good" or "Ok" and there was always plenty of choice, however some patients told us that the food was often served cold and was tasteless.
- The trust monitored patient experience across the wards for the period January 2016 to June 2016. The trust scored between 55% and 96% with three wards scoring less than 60%, five wards scoring less than 70% and two wards scoring less than 80%. Only one ward scored 96%.

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- Staff had access to translation services for patients for whom English was not a first language, which was available via the telephone and could also be provided to face-to-face. Relatives told us that they would also translate for their relatives.
- Access to a psychiatric liaison team was available for patients within the hospital. Staff told us this team would be contacted for any patients with specific mental health needs.
- Wards had a range of information leaflets available. This included generic trust information on topics such as infection control, Patient Advice and Liaison Service (PALS), complaints and VTE, plus some relevant diagnosis/condition specific information on what to do following a heart attack, blood thinning and depression after a stroke. Patient information and advice leaflets were available in English, but were not available in any other language or format.
- Staff in endoscopy had identified Turkish, French and Polish as the most commonly spoken languages other than English amongst their patients. To meet their needs, information leaflets about preparing for endoscopic procedures were available in these languages.
- The endoscopy unit had two recovery areas, one for men and one for women. There had been no reported mixed-sex breaches in this unit and single-sex shower and toilet facilities were provided.

Learning from complaints and concerns

- Data provided by the hospital showed there were 93 formal complaints made within the medical services between July 2015 and July 2016. 54% (50) of all complaints related to aspects of clinical treatment. The main themes highlighted in these complaints were general lack of care and communication. There were also several complaints which related to not being discharged with the correct equipment or medication. 68% of the complaints were upheld.
- Complaints were discussed at monthly clinical governance meetings. We saw that complaints were monitored and outcomes recorded with details of action points and learning identified.
- Staff we spoke with told us that they rarely had feedback about complaints or learning from them.

Are medical care services well-led?

Requires improvement

We rated well led as requires improvement because:

- The trust had a dementia strategy in place however of the 23 action points seven had been completed and 16 remained outstanding. The action plan did not detail a time frame for completion. The trust had not prioritised the dementia strategy however since the arrival of the new executive team this was beginning to change.
- Monthly ward meetings did not disseminate learning from incidents or complaints.
- The trust had a zero tolerance policy for staff speaking in other languages than English. We observed this on some wards and saw no action was taken to address this.
- Staff we spoke with that worked on Pymmes Zero ward told us that they had not been involved in any of the refurbishment plans to make the ward dementia friendly. However, we were told by the trust that the ward manager and matron for Pymmes Zero ward had been involved in planning the refurbishment

However:

- Staff told us that some members of the new executive team were visible on the wards, some staff we spoke with felt more confident that things were changing.
- The leadership team responsible for the endoscopy unit had included staff at all levels in plans for the temporary move of the unit, including how the unit would operate on their return after the refurbishment.

Leadership of service

- The medical and medical specialities crossed over two clinical business units (CBU). There was a managing director, service manager, head of nursing, and a clinical director responsible for each CBU. The CBU2 included care of the elderly, general medicine, medical oncology, respiratory medicine, gastroenterology, endocrinology and nephrology. The acute stroke unit was part of CBU3. There were three service managers allocated to the division. Each speciality had a clinical speciality lead allocated.
- A structure was in place to provide support to staff at ward level through ward managers and matrons. The matrons were visible on the wards. We saw that wards

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had monthly wards meetings and that these were minuted we found they were reactive and focused on emerging day-to-day issues, rather than long term plans and improvements such as incidents, PU care, complaints and patient experience.

- Staff told us that some members of the new executive team were visible on the wards, some staff we spoke with felt more confident that things were going to change. Staff told us the trust “feels it going in the right direction” and had “turned the corner”.
- Staff reported that the chief executive team had more involvement in the trust induction which they felt was a positive. Consultants said that the new chief executive communicated via email regularly which all staff received.
- Across the wards matron undertook a back to the floor exercise on a weekly basis to complete a matron's score card which included a records audit. We observed that this was in place.
- The trust had recently introduced “2 at the top” meetings which were wards leadership meetings between ward managers and led consultant for the wards. We looked at 13 sets of minutes and saw these were mostly structured around the five CQC domains of safe, effective, caring, responsive and well led. Issues for escalation were mostly identified with a summary to be included in the CBU clinical governance meetings.
- The leadership team in endoscopy had created a number of new posts to help support staff run the unit safely and efficiently, which was increasingly busy. This included a deputy operations manager, an administrator dedicated to waiting list management and two apprentices to run the reception service.

Vision and strategy for this service

- Some staff we spoke with were aware of the trust's strategy ‘safer, better, faster’ to improve the flow and discharge of patients through the hospital. Staff told us that they received emails from the trust, however most of the staff we spoke with told us that they did not have the time to read them and that frequently they would only access their emails “every so often”.
- The trust had a dementia strategy in place, however of the 23 action points, seven had been completed and 16 remained outstanding. The action plan did not detail a time frame for completion. The trust had not prioritised the dementia strategy, however since the arrival of the new executive team, this had changed.

- The endoscopy service was due to move to another hospital in November 2016 as part of a refurbishment plan for the main unit. This was taking place with involvement from staff at all levels of the unit and staff told us they were very happy with both the arrangements for the temporary move and with the plans for the refurbishment.

Governance, risk management and quality measurement

- Clinical governance were in place across the medicine and the medical specialities were led by the risk and governance office. We reviewed the minutes of the 28 June 2016 and saw incidents, serious incidents, the risk register and complaints were discussed. The minutes did not record attendance at the meetings.
- Monthly staff meetings were held on wards however governance information such as dissemination of learning from incidents or complaints was not recorded as being discussed as part of team meetings.
- We saw evidence of clinical business unit's CBU risk registers which closely reflected our inspection findings. Within CBU2, 39 risks had been identified. Although it was usually clear which risks were being recorded and when these risks needed reviewing, not all the risks identified had action plans in place to address them or time scales in place for completion.
- The endoscopy service was due to move to another hospital in November 2016 as part of a refurbishment plan for the main unit. This was taking place with involvement from staff at all levels of the unit and staff told us they were very happy with both the arrangements for the temporary move and with the plans for the refurbishment. Arrangements for infection control, fire safety and medicines management reflected those of the main unit.

Culture within the service

- Senior and medical staff we spoke with told us that they felt the morale in medicine had started to improve, however most nurses we spoke with felt under pressure on the wards.
- Staff told us they mainly enjoyed their work. Some staff told us they felt they would be able to perform their jobs better if they had more staff on shift with them to share the workload.

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- The trust had a zero tolerance policy for staff speaking in other languages than English. We observed this on some wards and saw no action was taken to address this. Some staff commented that they found this frustrating.
- Sickness rates across the medical wards for nursing staff were low, ranging from 3% to 8%. This was similar to the average sickness rate for nursing staff nationwide.

Public and staff engagement

- The trust had various means of engaging with patients included surveys such as Friends and Family Tests and other inpatient surveys. The comments and results from feedback surveys were generally completed by patients prior to discharge. The results were reported at clinical governance meetings.
- The trust had recently introduced the North Mid Star of the month award to recognise staff that had gone that extra mile. Some staff we spoke with were not aware this had been introduced.
- Staff we spoke with that worked on Pymmes Zero ward told us that they had not been involved in any of the refurbishment plans to make the ward dementia friendly. However, we were told by the trust that the ward manager and matron for Pymmes Zero ward had been involved in planning the refurbishment. The patients and staff had been relocated to Tower Ward 4 whilst Pymmes Zero was closed.
- The leadership team responsible for the endoscopy unit had included staff at all levels in plans for the temporary

move of the unit, including how the unit would operate on their return after the refurbishment. Staff we spoke with felt positive about this and said the developments in the unit were exciting. Managers had also begun to facilitate meetings between multidisciplinary staff in the unit to ensure better working practices and to help staff understand each other's role.

- The endoscopy leadership team had engaged with an apprenticeship programme, with support from a trust coordinator. Two apprentices in the unit were responsible for the reception desk service, for which they had received numerous compliments from patients and their relatives for good service. The deputy operations manager had also been offered development and progression through the apprenticeship scheme, which represented a commitment to staff support and building capacity within the unit team.

Innovation, improvement and sustainability

- The trust had three 'safe, better, faster' projects underway across medicine and the medicine specialties to improve patient experience these were:
 - To manage patient flow across the wards
 - To improve patient discharge and delays
 - To develop a short stay unit for patients
- The trust was in the process of recruiting a clinical nurse specialist for dementia and falls prevention.
- The trust was working with the Royal Free Hospital to look at the provision of a 24/7 endoscopy bleed service.

Surgery

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

Information about the service

The North Middlesex University Hospital treated 16,919 cases within the surgery division in 2015/2016. It included 68% of planned elective and day case surgery and 32% of emergency case surgical procedures. The majority of cases were treated within the general surgery (38%), trauma and orthopaedics (23%), and urology (18%) among other specialities such as eye and breast surgery (21%).

There are three surgical wards, pre-assessment unit, day surgery unit, discharge lounge, and a surgical assessment unit (SAU) that assesses patients who have a confirmed or probable surgical condition. Patients are referred to the SAU by their GP or are admitted via the emergency department. There are emergency surgeons, a 24-hour emergency theatre and a dedicated daily trauma list. There are eight operating theatres including one dedicated to emergency cases and another one to interventional radiology. There is a stage one recovery area and a stage two recovery area, from which day patients are discharged.

We visited pre- assessment clinics, theatres, anaesthetic rooms and recovery areas, day surgery unit, discharge areas, and post-surgical wards. We also visited interventional radiology services and preoperative assessments unit.

We spoke with 16 patients and their carers and relatives and 92 members of staff including senior and junior doctors, nurses, allied health professionals, ward

managers, senior staff and other support staff such as cleaners or ward clerks. We reviewed 25 patients' records and medication records and observed care being delivered on the wards and in theatres.

Surgery

Summary of findings

We rated this service as good because:

- All observed interactions between staff and patients were positive. Feedback from patients and relatives was good and they felt they were treated with courtesy, respect and compassion by staff. Staff maintained patients' privacy and dignity.
- Patients' nutritional needs were assessed and catered for appropriately.
- Patients were supported with pain management and said someone regularly checked them to ensure they were comfortable and they were offered pain relief when needed.
- Patients had access to an immediately available, fully staffed emergency theatre and a consultant 24 hours a day.
- All staff we spoke with demonstrated a good awareness of policies and how to access them. Local policies and guidelines were based on appropriate national guidelines
- The hospital consistently met the referral to treatment standard and performed better than an average English hospital.
- The hospital participated in national audits such as joint registry, national hip fracture, and the national emergency laparotomy audit. The hip fracture audit indicated the hospital performed better than the England average for patients undergoing surgery within 36 hours of admission. The indicator related to patients admitted to an orthopaedic ward within four hours was significantly better than the average for London hospitals. The hospital performed better than the England averages for two of the three knee-replacement indicators.
- Staff had access to data which supported service quality monitoring and they were able to use it to inform service delivery.
- The rate of cancelled operations was consistently lower than the England average and if cancellations occurred, all patients were treated within the subsequent 28 days.
- There were no delays in patient transfers from recovery to the ward. Most surgical patients were treated on surgical wards.

- The hospital had developed innovative pathways where surgical patients could avoid re-admission by involving the 'hospital at home' team and surgical assessment unit in their care.
- There were daily preoperative assessment clinics with a walk-in service available to all patients.
- We observed good multidisciplinary team working across the department.
- There was effective and well embedded clinical governance structure.
- The local leadership was well established and could provide sufficient oversight of activity within the division. The division had a local annual strategy which reflected departmental needs.
- Staff felt positive about the changes in the trust's senior management team and said communication and organisational culture was improving. They felt respected and valued by the managers and matrons.
- There were sufficient staffing, including doctors, nurses and theatre staff to meet patients' needs.
- We observed that there were effective infection prevention and control measures in place. We saw staff practice appropriate hand hygiene. The hospital was clean and there was a low rate of surgical site infection. There were no hospital acquired MRSA infections reported for the surgery division in 2015/2016.
- In elective and non-elective treatment cases, the observed emergency readmissions rate was within expectations.
- Emergency medicines and equipment was available to staff to allow prompt response in emergency.

However:

- The departmental risk register did not fully indicate how risks were mitigated and who was responsible for implementing actions.
- Actions in response to the never event were not fully implemented.
- Patients with pressure ulcers had not had the incident electronically logged despite staff's awareness of the requirement of recording pressure ulcers. They did not routinely raise a safeguarding alert in cases where a patient acquired a severe avoidable pressure ulcer during their stay at the hospital.

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- The hospital did not comply with the national guidance which recommends that the ratio of recovery beds to operating theatres should not be less than two.
- Bowel cancer patients' related data suggested the risk-adjusted two-year post-operative mortality rate was much higher than the national average. The clinical audit related to patients admitted with hip fracture in 2015 indicated that risk-adjusted 30-day mortality rate, although significantly better than during the previous year, was worse than expected.
- None of the nursing staff working on surgical assessment unit completed advanced life support training. The Resuscitation Council recommends that all staff working in acute areas complete advanced life support training.
- Reporting of actions from mortality and morbidity meetings was not formalised to allow learning and actions to be captured and shared across the trust.
- Individual venous thromboembolism risk assessments (VTE) were not fully completed.
- The pharmacy team did not meet their 2 hours target for average waiting time for a patient discharge prescription.
- Average length of stay at the hospital was longer than the England average for elective trauma and orthopaedics, general surgery and urology patients. It was also longer than the England average for non-elective urology.
- The utilisation rate for operating theatres was low and the hospital needed to improve efficiency within theatres.

Are surgery services safe?

Requires improvement 

We rated the safety as requires improvement because:

- Actions in response to the never event which occurred on a surgical ward in February 2016 were not fully implemented.
- Staff were not routinely recording pressure ulcers as incidents on hospital's electronic incidents reporting system. They did not routinely raise a safeguarding alert in cases where a patient acquired a severe avoidable pressure ulcer during their stay at the hospital.
- The trust did not undertake observation audits to review if all 'five steps to safe surgery' and surgical safety checks were undertaken correctly.
- None of the nursing staff working on surgical assessment unit completed advanced life support training. The Resuscitation Council recommends that all staff working in acute areas complete advanced life support training.
- Reporting of actions from mortality and morbidity meetings was not formalised to allow learning and actions to be captured and shared across the trust.
- Individual venous thromboembolism risk assessments (VTE) were not fully completed.

However:

- Wards were in a good state of repair.
- There were sufficient staffing, including doctors, nurses and theatre staff to meet patients' needs.
- We observed that hand hygiene practice was appropriate.
- There was a low rate of surgical site infection.
- There were no hospital acquired MRSA infections reported for the surgery division in 2015/2016.
- Emergency medicines and equipment was available to staff to allow prompt response in emergency.

Incidents

- All staff we spoke with were aware of how to report an incident. Staff received acknowledgment when they reported an incident but they did not always receive individual feedback. However, learning from incidents

Surgery

was discussed as part of team meetings and emailed to staff. Staff heard about major incidents, such as coroners inquests, and 'lessons learnt' were communicated with them.

- There was one never event which was an incident involving wrong route of administration of medication, which occurred in February 2016 on ward S2. The incident potentially contributed to the patient's death. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Staff were aware of the never event, however, the investigation was ongoing and senior staff were awaiting the final report in order to share the learning. Staff told us safety huddles were introduced in response and they had numerous discussions related to administration of enteral and oral medication. Action plan in response to the incident mentioned that red tabards with 'do not disturb' sign on it were to be introduced to indicate nurses were dealing with medication and minimise disturbance. We saw them in use on surgical wards. The action plan also stated bank and agency staff were required to confirm that they achieved competency in giving IV medications. However, staff told us that this requirement was not implemented as they did not have to show proof of intravenous fluid administration (IV) training prior to administering IV medication.
- Seven serious incidents were reported between August 2015 and July 2016 for the division through Strategic Executive Information System (STEIS). These related to: delay in diagnostic, treatment delay, suboptimal care of the deteriorating patient and a fall which met serious incident reporting criteria. We observed that incidents were adequately investigated and root cause analysis was completed with learning points identified.
- Safety alerts were monitored and nurses we spoke with were aware of the most recent critical safety alerts which were relevant to their specialities.
- The hospital reviewed deaths to ensure that patients were not dying as a consequence of unsafe clinical practices. The mortality and morbidity meetings took place monthly at speciality level and were led by a speciality lead. Surgical division morbidity and mortality

meetings took place, however, the reporting of actions from these meetings was not formalised to allow learning and actions to be captured and shared across the trust.

- Nursing staff were not routinely recording pressure ulcers as incidents on hospital's electronic incidents reporting system. We reviewed records and noted that not all cases when a patient was admitted with, or acquired pressure ulcers were recorded as incidents. This meant there was no record which would allow staff to analyse trends, prompt investigation, and ensure trust policies related to incidents were followed in order to prevent future occurrence.
- The Duty of Candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Staff had an understanding of the DoC. They gave us examples of when they applied the principle of the duty of candour by apologising and being open and transparent with patients. The examples related to delays in treatment or to the never event on ward S2.

Safety thermometer

- Six hospital acquired pressure ulcers were reported to the Patient Safety Thermometer (PST) between June 2015 and June 2016.
- Over the same period no falls with harm or urinary tract infections in patients with a catheter were reported to the PST. However, the divisional performance dashboard indicated that there was 47 falls from June 2015 to June 2016. It was higher than the 11 falls target set for the division.
- There were no VTE cases (venous thromboembolism-deep vein thrombosis and pulmonary embolism) reported on surgical wards. We observed that VTE risk assessments were not fully completed. The hospital audited if patients had a documented VTE risk assessment and the records indicated 100% compliance with the requirement on all three surgical wards in 11 out of 12 months from September 2015 to September 2016. This audit did not check if records were appropriately and fully completed. Another audit undertaken in November 2015 on ward S2 indicated that all patients were assessed but only 25% forms were completed fully.

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- We saw patients used compression stockings when they were being prepared for theatre. In theatres staff used a mechanical prophylaxis system designed to reduce the incidence of VTE.
- NHS Safety Thermometer information was displayed at the entrance to the wards. This included information about falls and new pressure ulcers in the area. We noticed on ward T3, the ward received a trust award for achieving 600 days without C Diff. However, all of the surgical wards displayed incidences of either falls or pressure ulcers in the last months (August and September 2016). There was a case when patient acquired a grade 4 pressure ulcer on ward S3. There were seven patients with moisture lesions on ward S3; records did not clearly indicate what was the cause of these lesions (i.e. incontinence, perspiration), and if suitable advice was obtained to manage it.

Cleanliness, infection control and hygiene

- Hand washing facilities and alcohol gel were readily available on the wards. We observed staff were compliant with hand hygiene.
- Although staff told us they tried to ensure patients undergoing joint replacement surgery were cared for in a side room, this was not always possible. We observed patients were in mixed bays, next to other patients with infected wounds.
- There were clear signs on the side room door indicating when patients were subject to transmission precautions and we observed the doors were kept closed.
- Therapy staff provided cryotherapy to patient following knee replacement by using a cryo cuff device. The manufacturer's instruction is that the cuff is single patient use but we observed staff were cleaning the cuffs between patients and re-using. This poses an infection control risk.
- The hospital collected data related to surgical site infections for breast surgery, knee and hip replacements, repair of fractured neck of femurs and caesarean section. However, it was not analysed and used as a quality indicator to facilitate learning and prevention of potential infections. The hospital told us there were only nine surgical site infections in 2015/2016, all related to caesarean sections.
- The service did not use cleaning schedules or checklists to confirm when cleaning took place. We saw a treatment couch on ward S2 with a 6 inch tear and 3 recliner chairs that were torn. This meant that effective

cleaning and disinfection of the equipment could not be undertaken. We brought this to the immediate attention of staff. A replacement couch was put in place, and the recliner chairs were removed. In theatres we saw arm rests, usually attached to the operating table during surgery, had tears or were sealed using adhesive tape. Some of the equipment trolleys used in theatres were rusted at floor level, this corrosion also prevented effective cleaning.

- We observed disposable curtains around patients' bays were clean, they had a date for changing on them and all were in date.
- Personal protective equipment, such as gloves and aprons, was available for staff to use whenever necessary. We also observed that hand hygiene practice was appropriate. There was sufficient number of hand washing basins. There were hand sanitizers available in corridors and near each of the patients' bays.
- The trust's MRSA policy required all emergency and relevant elective patients to be screened for MRSA (methicillin-resistant staphylococcus aureus; a type of bacterial infection that is resistant to a number of widely used antibiotics). Pre-assessment nurses told us they screen every patient undergoing surgery during the appointment. However, the trust failed to provide us with information related to screening rates and we were not sure if they had audited compliance with the requirement. There were no MRSA infections reported for the surgery division in 2015/2016.
- Surgical instruments were collected for central sterile processing. Theatres staff told us they were satisfied with the quality of services provided.
- There were lead staff allocated for taking responsibility in infection prevention and control (IPC) on surgical wards and theatres.

Environment and equipment

- We observed the wards to be in a good state of repair; ward T3 had just undergone refurbishment. The wards were bright and airy and all equipment stores were well organised.
- All equipment we checked was serviced in the last year and had a label indicating they were clean and ready to be used.
- Re-validation of theatres was undertaken in July and August 2016 and it was consistent with the requirements

Surgery

as prescribed by health technical memoranda (HTM 03-01) which provides guidance on the design and management of heating and specialised ventilation in health sector buildings.

- The hospital met requirement set by the Department of Health on eliminating mixed sex accommodation in hospitals. Men and women were cared for and slept on separate wards or in individual rooms.
- There was sufficient storage within theatres, scrub rooms and recovery areas.
- Oxygen cylinders and fire safety equipment was checked, in date and ready to use. Emergency medication and resuscitation trolleys were checked daily on all of the wards we visited.
- The Association of Anaesthetists of Great Britain and Ireland recommends pre-use check on anaesthetic equipment to ensure the correct functioning. Record was not kept with the anaesthetic machine, as required by the guidance, to confirm that these checks were completed. Theatre staff told us checks were carried out but they were not always recorded in log books.

Medicines

- Most medicines were stored securely and appropriately, including those requiring refrigeration. Regular expiry date checks were in place on wards S3, T3 and in theatres and there were arrangements for ensuring medicines were available out of hours. On ward S2 we saw nine ampoules of local anaesthetic not stored in their original packaging, and that had past the expiry date. In pre-assessment clinics medicines that were to be disposed were not labelled. Staff said they checked stock and recorded when medicines were dispensed, however, when we checked the stock it was not agreeing with the written record. Staff said that the pharmacy team did not audit their medicines management arrangements. We brought these issues to the immediate attention of the nurses in charge, who arranged for disposal of the medicines and ensured stock was correctly recorded.
- The surgical wards had daily weekday pharmacy presence on the ward and had access to an on-call pharmacist out of hours. The pharmacy department organised daily topping up of theatres medication stock from a central store.
- Controlled drugs (CDs) were stored and managed appropriately. The CDs were checked twice a day by two registered nurses. In theatres the CDs were checked at

the end of each shift by two authorised staff members. A recent controlled drug audit by the pharmacy team (August 2016) indicated good compliance across the surgical teams, including 100% in some theatre areas.

- To enable patients to be discharged more efficiently small packs of common medicines were pre-labelled and stored on the wards. Two nurses, who were specifically trained to do so, dispensed these medicines and checked the accuracy. The prescriptions were signed by both nurses and a record made in the appropriate log. We noted that this log was not completed in line with the trust policy on one ward and corrections were frequently made to the existing stock level.
- A recent audit of waiting times for discharge medicines indicated that in June 2016 the target time of two hours was met 67% of the time. Staff we spoke with suggested that this was improving currently.
- Emergency medicines and equipment was available and checked twice daily in theatres, a complete check was done monthly or when used. All appropriate emergency medicines were available and easily accessible.
- The hospital's resuscitation policy stated that the emergency trolleys, containing emergency medication, were to be checked twice daily on wards by checking the numbered seal was in place. Once a month staff were required to break the seal, check each item, and re-seal with a new numbered seal. There was lack of clarity in relation to frequency of these checks on wards and they took place irregularly as staff did not know how often they were required to do it.

Records

- We noted that falls risk assessments were completed. The falls risk assessment form used on the ward advised staff to complete additional falls care plan for all patients at high risk.
- The Department of Health (DH) requires that VTE risk assessments take place for every patient, and that results are closely monitored. Only some VTE assessments were fully completed on surgical wards. Some of the assessments we saw were undated or patient's name was not recorded as staff did not put a patient's name stickers in a place provided.
- The trust organised urology health records and consent audit in October to December 2015 to assess compliance with national standards in health record

Surgery

keeping and identify areas of improvement. Although findings of the audit noted improvement when comparing with audit undertaken in 2016 there were still areas where significant improvement was required. The audit noted that the patients name was not always recorded on forms (40% of cases), NHS number was often missing (60%), staff did not sign records (44%) and name of the responsible lead clinician was not recorded (41%).

- There was lack of clarity in relation to how changes to theatre lists were communicated to doctors and theatre staff. We observed that on one occasion staff in theatres did not use an up to date theatre list. The list provided to them did not indicate changes implemented to it after it was printed out on the previous day.

Safeguarding

- Staff were required to complete level 1 and 2 safeguarding training for adults and children and the trust set a target of 90% for staff compliance with the requirement. Records indicated that only half of all staff working in the SAU completed the level 2 trainings (55%). Only 67% completed level 1 children safeguarding training. Compliance was also low on ward S3 with 55% completing level 2 adults training and theatres with only 48%. We noted that some medical staff were also due to complete the training with only 65% of general surgical medical staff and 71% ophthalmic and urology medical staff completing level 2 adults training. Although their compliance with level 2 children safeguarding level 2 training was slightly better (85%) it was lower than the expected participation level. Ward S2 and the pre-assessment clinics achieved the 90% target set by the trust.
- Records indicated that level 3 children safeguarding training was not offered to senior members of staff and that only one member of staff across the division completed it (ophthalmologist). Similarly level 3 adults safeguarding training was not provided.
- Overall staff working within the division had a good understanding of safeguarding procedures, they were able to provide us with some examples when protocols would be initiated and knew who to contact should they require additional support. However, nursing staff and healthcare assistants did not routinely raise a safeguarding alert in cases where a patient acquired a pressure ulcer during their stay at the hospital. Staff

working on wards and in pre-assessment clinics could not recall when they last heard of safeguarding alert being raised and of any actions being taken in response to safeguarding.

Mandatory training

- The hospital worked to achieve compliance rate above 90% with mandatory training across all of the departments. The trust expected staff to complete training in health and safety, manual handling, fire safety awareness, infection control, information governance, basic life support, conflict resolution, and equality diversity and human rights,
- Staff working on wards S2, S3, theatres, SAU, and pre-assessment clinic failed to achieve this target with training compliance rates between 72% and 82%. Staff working at T3 ward achieved 93%.
- Only 66% of all staff working within the surgery division completed basic life support training, with the lowest compliance level among staff working on the SAU (28%). Immediate life support training was completed by 65% of anaesthetics medical staff 66% of urologists and 75% of general surgical medical staff.
- All staff we spoke with told us they were allocated paid time off to complete their mandatory training. We observed in staff rooms on the surgical ward that ward managers had lists up of staff requiring training updates and when they were booked on. Staff told us they were aware of when their training was due, and the ward manager also kept a record and planned the roster to ensure they attended their training.
- Mandatory training rates were displayed at the entrance of the wards.

Assessing and responding to patient risk

- National Early Warning System (NEWS) was used across the hospital to assist staff in the early recognition and escalation of a deteriorating patient. We saw NEWS documentation was mostly appropriately completed. Situation-Background-Assessment-Recommendation (SBAR) framework was used to support staff in escalating concerns in a clear and concise manner. Staff were familiar with those tools and knew how to escalate concerns related to patients' wellbeing. We saw, in records we reviewed, that staff appropriately escalated deteriorating patients.
- We observed patients on wards had emergency buzzers within their reach and this was responded to promptly.

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- As indicated by the hip fracture audit (2015) 100% of patients admitted with hip fracture had specialist falls assessment performed. It was in line with the London average (99%) and slightly better than the England average (96%). The trust achieved the same result as during the previous year.
- World Health Organisation (WHO) surgical checklist was in use in operating theatres. We observed that all three steps of the WHO checklist was completed (sing in, time out, sign out) and the procedure appeared embedded in staff practice. There were formal briefings and debriefings as recommended by the five step approach to safer surgery however this were not routinely attended by all staff present during surgery. For example, we observed briefing taking place without the surgeon being present. The addition of team brief and debriefing sessions at the beginning and the end of theatre lists is advocated by the Patient Safety First Campaign and the National Patient Safety Agency (NPSA) as an addition to the WHO Surgical Safety Checklist. It requires all staff participating in the procedure to be present during the team brief.
- The hospital audited use of WHO checks, by looking at random selection of WHO forms by ward clerks, in September 2016. Full completion rates fluctuated between 65% and 87% (July 2015 to August 2016). Overall the audit noted that improvement to 'the sign out' process was required across surgical services and ophthalmology department needed to improve their practice. It also noted gradual improvement over 2015/2016. The trust did not undertake observation audits.
- Staff working within the surgical assessment unit (SAU) assessed patients who had a confirmed or probable surgical condition. Patients were referred to the SAU by their GP or are admitted via the emergency department, often with a serious condition when a further investigation was required. None of the nursing staff working within the unit completed advanced life support training. The Resuscitation Council recommends that all staff working in acute areas completes advanced life support training to ensure they are able to recognise and treat the deteriorating patient using a structured approach and manage a cardiac arrest. The trust provided staff working at the SAU with basic life support training level 1 and 2 (adults). Although all staff completed level 1 training only 28% of staff working at the SAU completed basic life support level 2 training.

Nursing staffing

- Overall nurses and doctors felt wards were sufficiently staffed. There was a sufficient number of operating department practitioners (ODP) and scrub nurses. Theatre manager was able to fill all shifts and temporary staff used were familiar with the hospital.
- Nursing staff used an acuity tool every few months to monitor safe staffing levels. However, no such tool was used daily to ensure staffing levels reflected the patient needs. Staff would use their clinical judgement and if additional staff was needed, the nurse in charge would complete a form that would be authorised by matron and the head of nursing. This was often done for patients who were assessed as requiring one to one supervision. Staff told us there were plans to introduce a daily acuity tool in the last quarter of 2016.
- Expected and actual staffing levels were clearly displayed at the entrance to all the wards we visited. On the days of our inspections, we observed staffing levels were as planned.
- Bank and agency staff underwent a thorough induction process on their first shift. We saw evidence of some completed induction paperwork.
- The nursing staff vacancy rate recorded for the surgical wards in 2015/2016 varied between 4% (SAU) and 13% (T3) with a low turnover rate of 0% (SAU and S3) to 6% (T3). In theatres the vacancy rate was 9% and the turnover rate 3%. The hospital average vacancy rate was 9% and turnover rate 5%.
- Sickness rate for nursing staff was between 2% (S3) and 7% (theatres) overall it was lower than the hospital average (7%).
- Records indicated the use of nursing agency staff from in 2015/2016 varied from 0% to 20%, with the average 8.7% of shifts being allocated to agency staff on surgical wards and in theatres. It was lower than the hospital average of 11.9% and within the limit suggested by the best practice guidance which suggests that no more than 20% agency usage per shift.

Surgical staffing

- The surgical assessment unit had access to a registrar and specialty doctor without theatre commitments, and this facilitated a prompt response to requests for advice and treatment.

Surgery

- There was a sufficient number of doctors to staff wards and theatres, including out of hours and in emergency. We saw rotas for individual specialities which clearly indicated which doctor had the on-call responsibilities.
- Majority of the doctors employed by the trust were specialist consultants (38% of all doctors), they were supported by registrar doctors (StR 1-6; 35%). The percentage of consultant was lower than England average (43%) and number of registrar doctors was in line with the England average (35%). Total number of foundation year one and two doctors (16% of all doctors) was slightly higher than the England average (11%). The surgical division employed slightly more middle career doctors (at least three years at 'senior house officer' level or a higher grade within their chosen speciality) when compared with England average (11% against 10%).

Major incident awareness and training

- The trust had an emergency preparedness, resilience and response policy which was reviewed every three years. The plan was guided by the Civil Contingencies Act the NHS Emergency Planning Guidance 2005. Nurses and ward managers were aware of the emergency procedures; they told us plans were tested on a number of occasions. There were protocols for responding to emergencies such as operating theatres failure, electricity supply failure. Protocols highlighted priorities which would be given to the continuation and restoration of those services and functions which were deemed to be critical to the performance of the hospital. The trust assessed that a 'critical tolerable loss' of capacity in theatres and in elective surgical care would be a maximum of 4 hours.
- Business continuity planning training for matrons was provided in September 2015. Dedicated staff also attended training in emergency planning, major incidents and emergency, business continuity planning in case of IT system failure or loss of diagnostic services. Nurses from surgical wards in March 2016 received training on ward fire evacuation.
- The escalation plan for when capacity did not meet demand was implemented on one day during the week of the inspection when an incident was declared because of a surge in demand in emergency department and lack of hospital beds availability. Although in surgery, this resulted in cancellation of

elective operations we observed that staff acted effectively and were able to resolve the issue promptly by prioritising patients' discharges and coordinating work across divisions.

Are surgery services effective?

Good



We rated effective as good because:

- All staff we spoke with demonstrated a good awareness of policies and how to access them. Local policies and guidelines were based on appropriate national guidelines.
- The hospital participated in national audits such as joint registry, national hip fracture, and the national emergency laparotomy audit.
- Patients' nutritional needs were assessed and catered for appropriately.
- Patients were supported with pain management and said someone regularly checked them to ensure they were comfortable and were offered the pain relief when needed.
- In elective and non-elective treatment cases, the observed emergency readmissions rate was within expectations.
- The hospital performed better than the England averages for two of the three knee-replacement indicators.
- Patients had access to an immediately available, fully staffed emergency theatre and a consultant at any time of the day or night.
- We observed good multidisciplinary team working across the department.
- Staff obtained patient's verbal consent prior to any simple procedures performed at bedside; written consent was obtained prior to surgery. Patients said they were provided with information which supported them with treatment related decisions.
- Staff were knowledgeable and had skills required to perform their job effectively.

However:

- The hospital did not comply with the national guidance which recommends that the ratio of recovery beds to operating theatres should not be less than two.

Surgery

- Bowel cancer patients' related data suggested the risk-adjusted two-year post-operative mortality rate was much higher than the national average.
- The clinical audit related to patients admitted with hip fracture in 2015 indicated that risk-adjusted 30-day mortality rate, although significantly better than during the previous year, was worse than expected.

Evidence-based care and treatment

- We saw evidence the local policies and guidelines were based on national guidelines such as the National Institute for Clinical Excellence (NICE). We reviewed the fractured neck of femur pathway and saw that it was based on NICE guidelines.
- Enhanced recovery programmes were used for colorectal, orthopaedic and gynaecological surgery as recommended by the NHS Institute for Innovation and Improvement. The enhanced recovery programme was well embedded for all elective joint replacements.
- The hospital participated in national audits such as joint registry, national hip fracture, and the national emergency laparotomy audit.
- The trust had a hospital formulary which listed medicines the pharmacy stocked with guidance on their prescribing to promote effective prescribing.
- London quality standards self-assessment indicated the hospital achieved all standards set for emergency fractured neck of femur operations. Cases were prioritised on planned emergency lists to allow operation within 24 hours of admission to the hospital as recommended by the National Institute for Health and Care Excellence (NICE) guidance. Emergency admissions for fractured neck of femur were seen and assessed by a consultant orthopaedic surgeon, a consultant geriatrician and a consultant anaesthetist within 12 hours of the decision to admit as required by the guidance.
- The trust did not complete regular audits to prevent surgical site infections during pre-operative period, and post-surgery to check if patients' body temperature and glucose levels in diabetic patients were adequately maintained. The audit would allow ensuring adherence with the National Patient Safety Agency and the Department of Health guidance.
- Although prophylaxis was routinely used, not all of the patients were fully assessed in relation to the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) as required by the guidance on

reducing the risk in patients admitted to hospital. NICE recommends that all patients should be assessed for risk of developing thrombosis (blood clots; VTE assessment) on a regular basis. We observed that the hospital did not fully comply with this recommendation. Many VTE assessments, across all surgical wards, were not completed, some were not dated and others did not include a name of person carrying it out.

- The hospital did not comply with the national guidance issued by the Association of Anaesthetists of Great Britain and Ireland, related to recovery room facility. This guidance recommends that the ratio of beds to operating theatres should not be less than two. There were ten recovery bays for eight operating theatres. We did not observe it causing any delays to patients leaving theatres.

Pain relief

- Patients we spoke with were given information about pain and said someone regularly checked them to make sure they were comfortable and were offered the pain relief when needed.
- Staff used standardised pain assessment tools and pain scores were recorded consistently in the records we reviewed.
- The specialist pain team reviewed all post-operative patients and advised the medical and nursing team in how to optimise pain control.
- The specialist pain team consisted of three full time nurses and were about to recruit another nurse to expand the service to seven day working. The pain team carried out a daily ward round and were supported by an anaesthetist on the rounds twice a week.
- Seventy two percent of patients participating in the cancer patients experience survey 2015 said hospital staff did as much as they could to help control pain all of the time. The result was much lower than the national average 84%.
- London quality standards self-assessment indicated all patients were routinely offered fascia iliaca block (a localised anaesthetic) as soon as possible after admission in order to provide them with optimal pain control.

Nutrition and hydration

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- All patients were assessed using a five-step screening tool to identify adults who are malnourished, at risk of malnutrition (undernutrition), or obese (MUST assessment). We saw evidence of dietician input in the records we reviewed.
- Patient had their intake recorded in fluid balance and food chart. However, in the records we reviewed, we saw that the fluid balance charts and food charts were not consistently recorded. In some cases, the oral intake was recorded but the output section was blank. In other cases, some output was recorded but the overall fluid balance was not calculated.
- The red tray system was in use to identify patients who required supervision or assistance with their feeding. We saw it was highlighted in the handover sheet and the housekeeper was also alerted to these patients. Staff were allocated to assist with feeding at mealtimes.
- Patients told us they were mostly satisfied with the food provided at the hospital. We observed those who found it difficult to transfer had food within their reach. All patients had a water jug within reach.
- We saw that menus catered for cultural preferences of patients.

Patient outcomes

- The hip fracture audit indicated all patients admitted with hip fracture in 2015 were assessed for bone protection medication (England average 96.5%). The hospital improved its results when comparing with the previous year (91%). The same audit suggested that the 18.2 days mean length of total trust stay was longer than the England average of 15.7 days. Return to original residence within 30 day rate (54%) was in line with the England average. 0.9% of patients required reoperation within 30 days, it was slightly better than the England average of 1.1%. The audit also indicated that risk-adjusted 30-day mortality rate of 9.4%, although significantly better than during the previous year (12%) was still worse than the expected 7.5%.
- The national bowel cancer audit (2014) is a national clinical audit for bowel cancer, including colon and rectal cancer. Number of patients past surgical resection, who were ill and needed to remain as an inpatient for longer than five days, was higher at the hospital (91%) than the national average (69%). All patients were seen by a clinical nurse specialist (national average 88%). The hospital reported that all patients were recorded as having had a CT scan and it

was better than the national average (89%).

Risk-adjusted 90-day post-operative mortality rate (4.6%) was slightly worse than the national average (4.4%). Similarly risk-adjusted 90-day unplanned readmission rate at 19.6% was in line with the expectations (19.2%). However, data suggested the risk-adjusted 2-year post-operative mortality rate (36.1%) was much higher than the national average (22.7%).

- In the oesophago-gastric cancer audit 2015, the trust was between the upper and lower quartiles for the proportion of patients diagnosed after an emergency admission. The case ascertainment rate was better than the national average. The trust did not report on post-operative mortality rate. The proportion of patients treated in the clinical network was similar to the national figure.
- In the national emergency laparotomy organisational report 2014, the trust answered “available” to 19 of 28 applicable questions. Pre- and post-operative input from elderly medicine for elderly patients was available on request.
- We noted that in elective cases, the observed emergency readmissions rate was within expectations for urology, trauma and orthopaedics, and general surgery in 2015/2016 (patients who return to hospital within 28 days post discharge from hospital).
- For non-elective treatments in general surgery (88) and urology (95), the readmission rate was better when compared with the England average (100). For trauma and orthopaedics (102) it was slightly worse than the average (100).
- In the patient reported outcome measures the trust performed worse than the England average for one groin hernia indicator and one hip replacement indicator. It performed better than the England averages for two of the three knee-replacement indicators.

Competent staff

- Staff we spoke to were clear on their responsibilities, aware of patients’ individual progress and able to answer patients’ questions in a confident manner.
- Most of the nursing and operating department practitioners (ODP) staff working in theatres were appraised annually. The trust did not provide us with appraisal compliance information for individual departments and wards. Overall 34% of all doctors and

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79% of all nurses were appraised between April 2015 to March 2016. Ninety one percent of allied health professionals underwent appraisal during the same period.

- Theatre staff competency training was monitored and planned according to staff roles and responsibilities. It included training on use of specialist equipment and diagnostic tools.
- All staff attended a clinical skills yearly update which covered areas such as catheter care, IV and tracheostomy care. Bank and agency staff underwent a thorough induction and orientation. However, they did not have to show proof of intravenous fluid administration (IV) training prior to administering IV medication. Staff were asked if they were competent but did not have to produce their certificates. It was contradictory to the action plan prepared in response to the never event in February 2016, which stated bank and agency staff were required to confirm that they achieved competency in giving IV medications.
- The trust monitored whether staff maintained their registration with a suitable membership body such as the Nursing and Midwifery Council. It included doctors' appraisal and revalidation in line with recommendations of the General Medical Council on doctors' fitness to practice.

Multidisciplinary working

- Daily handover meetings took place at a specific time and the meeting was attended by the nurse in charge, discharge specialist nurse, occupational therapist and physiotherapist to discuss discharge plans.
- Staff we spoke with told us there was good working relationships between the ward nurses, the therapist and other specialist nurses.
- Nurses told us the ward pharmacist was working closely with the ward staff to ensure quick turnaround of 'to take home' medication.
- The discharge specialist nurses worked closely with nurses and therapist to ensure patient were discharged safely. Staff liaised with external agencies to ensure patients received the appropriate support on discharge.
- All patients undergoing joint replacement surgery were offered a multidisciplinary led pre-operative education session attended by occupational therapist,

physiotherapist, nurse and pharmacist. In-patient physiotherapy and occupational therapy was routinely provided to all patients who underwent joint replacement surgery.

- The national hip fracture audit indicated that there was no orthogeriatrician weekend cover for the hospital, however, the ortho-geriatrician attended two rounds per week, and they also completed bone health assessments. Data indicated that 87% of patients admitted to the hospital with a hip fracture were offered senior geriatric review within 72 hours of admission; this was in line with the England average.
- There was strong collaboraton between the orthogeriatrician and the orthopaedic team for all elderly patients admitted for trauma or elective orthopaedic surgery. Patients admitted with a fractured neck of femur had their care transferred to the orthogeraitrician three days after their operation.

Seven-day services

- General surgery patients had access to an immediately available, fully staffed emergency theatre and a consultant on site within 30 minutes at any time of the day or night. General surgeon consultant on-call was freed up from elective commitments when on call to allow non-elective patients to be reviewed in a timely way as required by the London quality standards.
- Patients did not have access to interventional radiology (IR) 24 hours a day and services were provided Monday to Friday only. The London quality standard requires hospital to provide service within one hour to critical patients and twelve hours to non-critical patients.
- Emergency patients did not have access to comprehensive 24 hour endoscopy services that had a formal consultant rota 24 hours a day, seven days a week.
- Pharmacists visited all wards each weekday (Monday to Friday). The pharmacy department was open seven days a week but with limited hours on Saturday and Sunday.
- On-call physiotherapist was available for urgent chest physiotherapy during out of hours. Overall physiotherapists provided seven- day physiotherapy service for orthopaedic patients with one physiotherapist working at weekends. However, other surgical patients did not receive physiotherapy input at weekends unless they required chest physiotherapy.

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- Surgical patients had access to diagnostic imaging at all times.

Access to information

- The trust used an electronic patients' medical records system, which allowed clinical professionals to record and track the care, treatment and health management of patients in real time. It was used effectively to manage patients flow within the division.
- Doctors and nurses said they had access to information which supported clinical decisions; it included diagnostic imaging and other test results.
- Staff in pre-assessment clinics had access to patients' paper records which included a copy of the original referral letter, medical history, and results of diagnostic procedures. Many patients would walk-in after their outpatients appointment and they would bring their records with them. However, records that needed to be delivered by the medical records team were frequently missing. Staff were often provided with a temporary file, which only included the referral letter and results of the most recent diagnostic results. We looked through the clinic list and noted that on most days between two to four patients' records were not delivered or only temporary files were provided (approximately 5%).

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff explained patients' treatment options and risks and benefits of the proposed treatment during the preoperative assessment clinics. Some patients were required to sign the consent forms during the pre-assessment whilst others were consented on the day of the surgery. When patients were consented during pre-assessment appointment it would still be obtained on the day of surgery. We observed staff in theatres also confirmed with patients the procedure and asked them if they have provided consent.
- We observed staff obtaining patients' verbal consent prior to any simple procedures performed at bedside, for example when drawing blood for analysis.
- Nurse told us they were familiar with the Mental Capacity Act and Deprivation of Liberty Safeguards (MCA and DoLS), however, the trust failed to provide us with information related to MCA and DoLS training. Nurses told us this training was not mandatory. In response staff held discussions on principles of good clinical record keeping during their staff meetings.

- The trust carried out a sample consent form audit in April 2016 to check compliance with the trust consent policy and improve safer practice of consent within the hospital. It was noted that overall the trust made some improvement in standard of recording the information on consent forms. Provision of procedure specific information to the patient was noted in the consent form only on 16% of cases. Although 'stage 1' of consent forms were fully completed in 86% of cases, 'stage 2' of consent forms was signed and dated only in 42% of cases. Specialty leads were asked to re-audit consent practice within their area by the end of 2016, after implementation of recommendations highlighted in the report.
- Senior staff were aware of the DoLS principles and told us they completed DoLS applications for patients requiring 1:1 care but there were no patients under a DoLS during our inspection.
- There were procedures for obtaining consent from patients who did not have capacity to consent and staff we spoke to were aware of the role of the independent mental capacity advocate (IMCA) to safeguard people who lacked capacity. However, it was not always clear in which situations this would apply and who would be responsible for initiating the process.

Are surgery services caring?

Good



We rated caring as good because:

- All observed interactions between staff and patients were positive. Feedback from patients and relatives was generally very good and they felt they were treated with courtesy, respect and compassion by staff.
- Relatives told us the staff were helpful and gave them regular updates and that they felt suitably involved.
- Observations of care showed staff maintained patient privacy and dignity.
- In the Friends and Family Test the percentage of patients who said they would recommend the trust was generally high.
- Patients had access to emotional support when required.

Compassionate care

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- We observed several interactions between staff and patients and saw staff treated patients with compassion and kindness. Feedback from patients and relatives was generally very good and they felt they were treated with courtesy, respect and compassion by staff. However, some patients told us staff “do not care about people”, “some staff were rude” and “no one explained things”. Others said staff on wards took patients’ bloods at 3am after patients fell asleep.
- We observed staff ensuring patients’ privacy and dignity was respected when providing care by closing the door to side rooms and drawing curtains in the main bay.
- In the Friends and Family Test (FFT) the trust’s response rate was higher than the England average. General surgery ward had the lowest response rate at just over one in four. The percentage of patients who said they would recommend the trust in the FFT was generally high across all surgical wards. The lowest score was for general surgery ward in April 2016 (81.8%).
- The trust performed about the same as most other trusts that took part in the national inpatient survey carried out in August 2015 to January 2016.

Patient understanding and involvement

- Seventy three percent of patients participating in the cancer patients experience survey (2015 results) said staff explained how the operation had gone in understandable way. It was lower than the national average of 78%. The score was particularly low for breast operations with only 61% patients being provided with understandable information post operation (unadjusted score). The national average for breast operations was 77%.
- Patients told us they felt involved in planning of their treatment. Staff at the preoperative assessment clinic informed them of the relevant facts, answered any questions and gathered information about their health. All aspects of the hospital stay, operation and discharge was explained at pre-assessment. Patients we spoke with told us the procedure was fully explained during the consenting process and staff provided them with some written general information related to procedure. Whilst on the ward, staff kept them informed of their progress and their discharge plans. One patient told us the therapy staff spent a lot of time talking to their family to ensure a smooth transition from hospital to home took place.

- Patients undergoing hip or knee joint replacements were invited to attend the ‘bone school’ before their surgery. This allowed them to find out how they could prepare for their operation and what to expect when in the hospital and once they were discharged.

Emotional support

- The specialist nurses reviewed patients daily and provided some emotional support to patients and their relatives. Patients felt able to speak about their worries and said staff at the hospital were compassionate.
- The ward had information leaflets on display advising carers on how to access additional support.
- Patients had access to the hospital multi faith chaplaincy service.
- The hospital established user and support groups, which were run by former patients. This included colorectal cancer group and support group for patients with breast cancer.
- The cancer support centre offered information about cancer and staff working there helped with answering questions about cancer. The centre was managed by a cancer nurse supported by trained volunteers.
- Patients also had access to another cancer support centre run by a local charity and located in the radiotherapy and oncology waiting area. It helped patients emotionally and physically by providing complementary therapy services such as massage and counselling.
- The hospital worked in partnership with a charity which provided advocacy service offering statutory and informal advocacy services. This was to support people who had mental health needs, learning disabilities and sensory and communication impairments among others.
- Nurses and healthcare assistants told us they did not receive communication training which would support their skills in providing emotional support and breaking bad news.

Are surgery services responsive?

Good



We rated responsive as good because:

- There were no delays in patient transfers from recovery to the ward.

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- Most of surgical patients were treated on surgical wards.
- The rate of cancelled operations from April 2014 to March 2016 was consistently lower than the England average. If cancellations occurred patients were treated within the subsequent 28 days.
- There were no mixed sex accommodation breaches in the past 12 months.
- Changes implemented to surgical assessment unit and introduction of the 'hospital at home' team helped to manage the flow within the hospital and ensure patients were treated in an optimal environment.
- The hip fracture audit indicates performed better than the England average for patients undergoing surgery within 36 hours of admission. The indicator related to patients admitted to an orthopaedic ward within four hours; this was significantly better than the average for London hospitals.
- The preoperative assessment clinics run daily with a walk-in service available for all patients.
- There were effective systems to ensure patients' individual needs were identified and met by staff. This included an electronic 'flagging' system to identify patients with additional support needs and personalised '10 things about me' assessment.
- The hospital consistently met the referral to treatment standard and performed better than an average English hospital.

However:

- The pharmacy team did not meet their 2 hours target for average waiting time for a patient discharge prescription.
- Average length of stay at the hospital was longer than the England average for elective and trauma orthopaedics, general surgery and urology patients. It was also longer than the England average for non-elective urology.
- The utilisation rate for operating theatres was low and the hospital needed to improve efficiency.
- The trust did not routinely collect data to indicate if all qualifying patients were screened for dementia.
- Patients complaints were managed effectively, however, nurses and healthcare assistants were unable to tell us about recent complaints and the learning undertaken in response.

- Although we saw variety of information leaflets about procedures and after-care we found there were no printed materials available in languages other than English.

Service planning and delivery to meet the needs of local people

- The hospital had a fully staffed theatre available 24 hours a day to allow staff to perform immediate life, limb or organ-saving interventions within minutes of when decision to operate was made. This allowed staff to act in acute emergency without interrupting an elective list and to prevent cancellation of that list and re-booking the patients.
- London quality standards self-assessment indicated patients had discharge plan and an estimated discharge date was set no later than 24 hours post their admission. Nurses told us discharge summaries were easily accessible and prepared promptly to avoid delays. A process that allowed staff access to social services seven days a week helped to reduce delayed discharges.
- There was a designated surgical assessment unit to assess patients who visited the emergency department and had a confirmed or probable surgical condition. This allowed patients requiring hospital admission for surgery to be identified by staff quickly.
- There was sufficient number of single-bed rooms on each of the surgical wards for patients, which allowed increasing patients' privacy, dignity, and confidentiality. They also give patients more control over their immediate environment and patients reported they could sleep better because there was less noise. It also helped to prevent gender bed blocking and helped to prevent and control healthcare associated infections.
- The trust did not report any mixed sex accommodation breaches in the past 12 months.

Access and flow

- The hospital consistently met the referral to treatment standard (RTT) in 2015/2016 and performed better than an average English hospital. We observed that approximately 95% of trauma and orthopaedics, 94% for ophthalmology and 96% of urology patients received treatment within 18 weeks in 2015/2016 (admitted adjusted pathways). The rate was slightly worse for general surgery patients (91%).

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- Administrators checked theatre lists against surgeons work diaries to avoid cancellations and lists were set accurately. Surgery sessions were allocated according to patients' needs and case complexity. For example, staff said that patients with learning disability or those living with dementia, and those who were expected to take longer to recover post-surgery were operated first.
- The medical handover of patients took place twice a day. There were arrangements for the handover of patients at each change of responsible consultant or medical team. The consultant communicated changes in treatment plans to nursing and therapy staff promptly if they were not involved in the handover discussions.
- The specialist orthopaedic nurse was alerted as soon as a patient was diagnosed with a fractured neck of femur in emergency department (ED). They then met the patient in ED to ensure suitable treatment was provided and there were no delays. Patients were usually transferred to the orthopaedic ward within a few hours.
- The preoperative assessment clinics ran daily, with a walk-in service available for all patients coming from fracture clinic or outpatients appointment were surgery had been recommended.
- Wards' matrons were involved in bed management alongside the clinical site management team, the meeting was led by the managing director and each of the divisions were represented. It allowed for patients' needs to be prioritised and appropriate treatment and interventions commenced without delays. The team was able to forecast patient numbers and focused on individual specialities and patient's gender to ensure there were available beds for newly admitted patients.
- Matrons and ward managers discussed all elective patients requiring admission the day before and ensured a bed would be available.
- We were told that following a surgical procedure there were no delays in patients being transferred from theatre recovery to the ward.
- Nurses told us they felt all patients placed on other wards had received appropriate support coordinated by an appropriate consultant. Doctors said they were not often required to visit surgical patients on medical wards as they usually had suitable beds available. The trust told us between August 2015 and July 2016, approximately 84 surgical patients were placed in other departments' wards due to the lack of surgical beds. It was more common that medical patients were placed on surgical wards with 1,456 medical outliers in August 2015 to July 2016. When possible medical outliers (medical patients who could not be accommodated on medical wards) were transferred out of the surgical ward to make room for surgical patients.
- There were 260 out of hours transfer and discharges recorded for the surgical division between September 2015 and August 2016. These all occurred between 10pm and 6am. We were unable to analyse fully the impact for surgical patients, as the trust did not provide us with data relevant to individual specialities. Data did not differentiate between internal and external transfers.
- In 2016, wards were restructured to allow an increase in number of orthopaedic beds from 19 to 30 beds. This was in response to the surgical leadership team identifying growing number of orthopaedic outliers.
- The addition of a new surgical assessment unit (SAU), reduced pressure in emergency department and ensured surgical patients were reviewed by surgical teams without delays. The surgical assessment unit and day surgery unit staff worked flexibly across the co-located units to ensure patients were discharged in a timely manner.
- We observed that some beds on the day surgery unit were used for patients who should be placed on the SAU. These patients were monitored by nursing staff from the SAU and were moved to the SAU on the same day as soon as beds became available.
- Between April and August 2016 the majority of the SAU's patients stayed on the unit for less than 24 hours with approximately 30% exceeding the 24 hours period and staying for just over 48 hours.
- On three nights between June 2015 and July 2016, the day surgery unit was opened overnight to care for medical patients who could not be placed in the medical wards. When day surgery patients required overnight stay they were transferred to surgical wards. Between September 2015 and August 2016, 794 day surgery patients were required to stay overnight at the hospital. Of these the highest number were patients who had gallbladder removed (99), patients who underwent repair of inguinal hernia (28), and total prosthetic replacement of knee joint patients (27). In 165 cases, the procedure was described in the data as "unknown".
- Surgical wards were supported by the 'hospital at home' service which provided 17 'virtual beds' which were shared across specialities. The team was responsible for

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arranging care packages and support at home. The team liaised between primary care and community services to try to prevent readmission to hospital. Staff said the transition from hospital to home worked more effectively after the service was introduced. The team consisted of physiotherapist, occupational therapist, nursing staff and healthcare assistants. They received between five and 20 surgical referrals per month (December 2015 to August 2016). Although the number of referrals had steadily increased since the service had started, the hospital at home team felt the orthopaedic surgeons and surgical directorate did not utilise the service fully.

- There was a discharge coordinator allocated to three surgical wards to prevent any delays in patient discharges. However, the limited number of occupational therapist (OT) on the ward could sometimes lead to delays in patients with complex discharge planning needs being discharged. The OT explained they would normally prioritise patients who were medically fit for discharge rather than get involved with rehabilitation of all patients.
- The percentage of admitted surgical patients (completed pathways) that started treatment within 18 weeks of referral was consistently better than the England average between June 2015 and May 2016. Over 90% of patients started treatment within 18 weeks in all four surgical specialties.
- All patients whose operations were cancelled were subsequently treated within 28 days between April 2014 and March 2016.
- Cancelled operations were lower as a percentage of elective admissions than the equivalent England figure for August 2014 to March 2016. There was a downward trend in cancelled operations expressed as a percentage of elective admissions, which showed that the hospital was cancelling fewer procedures and was performing better than the national average. The rate of cancelled operations from April 2014 to March 2016 was consistently lower than the England average of between 1.2% and 1.5% and varied between 0.5% and 1.2% (between 20 and 60 cancelled operations per month). When operation was cancelled, due to unforeseen circumstances, the hospital was able to reschedule it in a timely manner.
- Average length of stay was longer than the England average for elective trauma and orthopaedics, general

surgery and urology between March 2015 and February 2016. Over the same period, length of stay was also longer than the England average for non-elective urology.

- The utilisation rate for operating theatres between March 2016 and May 2016 was low and varied between 62% and 81%. We did not observe it to have any impact on patients care; the hospital was working towards achieving 87% to improve efficiency.
- Theatre usage data collected by the trust indicated that in 6% of cases the surgery started later than planned and in 11% of cases theatres staff finished earlier than planned. The pain management team noted higher rate of delays in commencing theatre lists (12.4%) and when they finished early (21%).
- The hip fracture audit 2015 indicated that 81% of patients admitted with a hip fracture had surgery within 36 hours, either on the day of, or day after admission. The hospital achieved rates between 87% and 95% in most of the months in 2015/2016 with an exception of January 2016 when they only achieved 60%. Overall, the hospital performed better than the England average of 75%. We saw that 46.6% of patients had been admitted to an orthopaedic ward within four hours which was in line with the England average of 46% and significantly better than the 29% average for London hospitals.
- The target for average waiting time for a patient discharge prescription was set as two hours. The pharmacy audit indicated it was met only in 67% of cases.

Meeting people's individual needs

- Senior nurses told us patients living with dementia, children and other patients who required reasonable adjustments and enhanced discharge planning were first on the operation list giving staff additional time to arrange discharges. Staff were able to use a 'flag' within the patients' electronic record system to indicate special needs or if any adjustments to care and treatment was required.
- Patients' individual needs were highlighted by nurses during pre-assessment to allow adequate planning and preparation prior to their admission. For example, if more staff were needed to support patients living with dementia or if equipment was required for patients with physical disabilities. Staff had access to equipment to support people with mobility difficulties or those with high body mass index. All staff we spoke with had

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received dementia awareness training and were aware of the flagging system. Staff completed the '10 things about me' with patients and their relatives to enable them to better understand their patients and hence meet their specific needs. We saw completed '10 things about me' forms in some records we reviewed.

- Of patients admitted with a hip fracture in 2014, 99.6% were assessed by staff for confusion and other cognitive impairment as suggested by the hip fracture audit 2015.
- Nurses and doctors told us patients aged 75 and above admitted as inpatients were routinely screened for dementia within 72 hours of admission. However, the trust did not collect detailed up to date to indicate all qualifying patients were screened.
- There was a learning disability nurse working part-time at the hospital, staff on surgical wards knew who they were. The liaison nurse was notified of all admission and the destination of admission of patient with learning disability through the electronic patients' records system, provided the correct category was highlighted by staff. Nursing staff told us the specialist learning disability nurse reviewed each patient and provided advice to the ward team on how to best care for the patient.
- There were no unjustified mixed-sex breaches of sleeping accommodation reported by the hospital in 2015/2016. Men and women were cared for, and slept on different wards or in individual rooms. They did not share toilets or washing facilities.
- Patients' level of mobility were not clearly displayed so other staff who did not work with patients regularly were not aware of how a particular patient could transfer and mobilise. This posed a risk, especially on the orthopaedic ward as most patients have mobility problems.
- We observed there was literature available to patients in the preoperative clinics informing them of what the procedure involved and of aftercare. There were no printed materials available in languages other than English.
- Staff could access interpreters, via a phone service 24 hours a day. Face to face interpreters could be booked in advance. Turkish interpreters were based on site and available to come to the ward at short notice. This provided support for patients whose first language was not English.

Learning from complaints and concerns

- Patients we spoke to knew how to raise concerns. Patient information leaflets explaining service user rights, the trust's complaints process and the Patient Advice & Liaison Service (PALs) were available in wards, clinics and patient areas.
- Senior members of staff said learning from complaints was shared with staff through clinical governance meetings, wards and theatres meetings. However, nurses and healthcare assistants we spoke with were not able to tell us about recent complaints and the learning from these.
- Senior nurses told us all formal complaints were acknowledged within three working days of receipt. The trust set a deadline of 30 working days for a full response, in line with NHS guidance on how to respond to patients' complaints.
- The trust took on average 26.4 working days to respond to complaints, the CBU4 division took 35 days to fully investigate and close complaints. They had met its complaint response deadline target of 85% for acknowledging formal complaints within 48 hours for complaints received in 2015/2016 (89%).
- The hospital recorded 42 formal complaints for the surgery division which related to inpatient care. In 50% of cases, complaints have been upheld or partly upheld by the trust and records indicated that an apology was given and lessons were learnt by the service. Of these, 26 complaints were generic and related to 'all aspects of clinical treatment', 10 complaints related to admission or discharge arrangements, four to staff attitude and poor communication, one to lack of privacy and another one to loss of the patient's property during internal transfers.

Are surgery services well-led?

Good



We rated well led as good because:

- The local leadership was well established and could provide sufficient oversight of activity within the division.
- The division had a local annual strategy which reflected departmental needs.

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- Staff felt positive about the changes in the trust's senior management team and said communication and organisational culture was improving.
- Staff had access to data which supported service quality monitoring, they were able to use it to drive improvements and identify risks and trends.
- There was effective and well embedded clinical governance structure.
- Most staff we spoke with felt respected and valued by the managers and matrons.
- The hospital worked to develop innovative pathways where surgical patients could avoid admission and prolong hospital stay by involving the 'hospital at home' team and surgical assessment unit in their care.
- There was a monthly clinical governance meetings to review and monitored all aspects of patient experience and care. The representatives reported into the trust's risk and quality committee. There was a cross site representation both managerially and clinically at those meetings.
- The hospital used a quality monitoring dashboard which allowed effective monitoring of key performance indicators such as; safety thermometer data, theatre utilisation data, delays in access to diagnostic services, or in receiving treatment. It also monitored financial performance or staff related data such as training participation rate, vacancies, and temporary staff usage.
- Each of the wards was provided with key performance indicators to inform them how they performed in relation to safety, patients' experience, or clinical effectiveness. Senior nurses were aware how they performed in comparison with other wards, and of areas where improvements were required. Key findings and tables were also displayed on wards.

However:

- Departmental risk register did not fully indicate how risks were mitigated and who was responsible for implementing actions.

Vision and strategy for this service

- Staff were aware of the trust's strategic objectives which included: the provision of excellent clinical outcomes, positive experiences for patients and GPs, and provision of a service that was value for money for the tax payer. However, many were unclear of the future of the organisation as the senior management team, including the director of nursing and chief executive officer, changed shortly before our inspection. Staff felt that the new team were communicating effectively and many said they met new senior managers personally. However, they felt that the hospital needed some time to "settle down" and concentrate on service continuity and managing transition before developing new strategies.
- The division developed a new strategy each year, this was brief but speciality specific, and helped to highlight the most important developments staff were required to focus on. It also supported business cases as driven by divisional needs. The division presented a business case for a mobile laminar flow unit, a new electronic theatre management system, and development of one stop clinics to improve service flow (i.e. urology or shoulder injection clinic).
- There were senior nurses meetings where any performance issues, staffing and practice development was discussed with nurses. Outcomes from those meetings were shared with other staff during the ward or theatres meetings.
- There was a departmental risk register, which noted current risks related to: over reliance on temporary files from medical records affecting pre-assessment clinics, inappropriate use of day surgery unit areas for inpatients, and increase in patients' falls on ward S3. Although senior members of staff told us the risk register was frequently reviewed at the senior staff meeting we noted that 25% of the risks listed on the register were there for longer than two years. 66% had no action lead recorded and no due dates indicated. There were five serious incidents noted on the divisional risk register, without clearly specifying what the risk was and how it would be mitigated.

Leadership of service

- There was a managing director, service manager, head of nursing, and a clinical director responsible for the division (CBU4). The division included orthopaedics, general surgery, urology, pain management, critical care, anaesthetics, ophthalmology, and diabetic retinal eye screening services. There were two service managers allocated to the division. Each speciality had a clinical speciality lead allocated.

Governance, risk management and quality measurement

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- There were two matrons responsible for overseeing surgical wards. Both were new in post and staff felt they were “still finding their feet”. However, staff were optimistic about the future and have observed positive impact. They said matrons were proactive, visible, and staff felt supported by them. The head of nursing, who used to be a surgical matron, was also well known to staff, most said they were approachable and spoke fondly of them.
- The leadership of the trust changed in mid-2016 and in general staff we spoke with were complimentary of the new leadership team. They felt confident the new team would improve quality of care and standards at the trust.
- There was a theatres manager responsible for theatres and recovery area. Staff felt the service was well organised and managed well, they also said they were happy working at the hospital.
- The preoperative assessment team came under the same nursing governance structure which allowed clear lines of responsibility, and accountability for the overall quality of clinical care.
- Bed allocation was coordinated from the clinical site management office. Matrons felt involved in decisions related to bed management and said communication worked well.
- Nurses and healthcare assistants on surgical wards told us team meetings were organised monthly; most of them were able to attend ward meetings. There were also monthly theatres meeting which was attended by scrub nurses, operating department practitioners, healthcare assistants and others involved in day to day running of the department.

Culture within the service

- Staff we spoke with felt respected and valued by the ward managers and matrons. All but one told us the relationship between the medical and nursing staff was one of mutual respect. They felt confident to report any behaviour they felt were inappropriate and challenge their colleagues.
- Two staff members complained that they did not feel treated fairly and senior managers’ conduct and communication skills needed to improve as they displayed intimidating behaviours. Others told us the ward managers had an open door policy and that they felt confident to approach them with any issues, be in professional or personal.

- Although staff told us managers were “very keen to manage sickness”, they felt the managers and human resources department were supportive during the process.
- Doctors told us they liked working in the hospital and that they were well supported by the hospital and their colleagues.
- Results of the friends and family test (FFT) organised for staff twice a year, indicated that 59% of staff would recommend the hospital as the place to work in March 2016. 59% of them would recommend care at the hospital. The results were in decline when compared with September 2015 results, we also noted staff participation in the survey was low (7%).
- We observed that individual teams worked well together and communicated effectively, they were committed and focused on patients care.

Public and staff engagement

- The hospital participated in NHS Friends and Family Test and undertook family satisfaction surveys. Feedback provided by patients and their families was positive.
- There were regular team meetings organised on wards and theatres. Staff said these meetings were useful and they could openly discuss and issues and service improvements ideas.
- Staff told us they received staff newsletter which informed them of current trust wide development. They also received emails from the new senior management team who shared news and any future developments with them.
- The trust organised a staff recognition scheme to appreciate “the hard work, dedication and commitment of staff and their efforts to improve services”. In 2015 the division’s matron, head of nursing at the time, received an award for leadership. One of the surgical care nurses was awarded for ‘top quality patient care’. In September 2016 the trust launched new award scheme based on trust values. The ‘North Mid Star of the Month’ award celebrated the contribution of staff and aim to recognise staff members who went the extra mile in their job.

Innovation, improvement and sustainability

- The department recruited an orthopaedic nurse specialist dedicated to hip fractures in elderly and enhanced recovery in orthopaedics. They also employed emergency surgical practitioner who supported emergency on call team, reviewed patients in

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emergency department and supported implementation of surgical pathways. In addition, the trust recruited breast specialist nurse to support the oncoplastic breast patients and clinical nurse specialist working with colorectal surgeons with an aim to reduce the need for surgical interventions.

- The trust participated in the national pilot for on-line pre-assessment with a view to speed up a process, and improve patients' experience. The pre-assessment nurse told us patient had a choice to undergo full pre-operative assessment at the clinic or complete it at home after basic measurements were taken at the hospital.
- The hospital worked to develop pathways where surgical patients could avoid admission and prolong hospital stay by involving the 'hospital at home' team and surgical assessment unit in their care. Many patients were referred directly to the SAU by their GP with a view to ease pressures on emergency department; the unit accepted outpatient clinics' urgent referrals. Patients, who needed additional support, ambulatory care, or a medical review a few days after hospital discharge, were asked to visit the SAU for a pre-planned appointment organised on doctors' request at the time of their discharge. The unit also aimed to provide second stage recovery at weekends for trauma patients.

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

Information about the service

The critical care complex (CCC) at North Middlesex University NHS Hospital comprises of a high dependency unit (HDU) and an intensive care unit (ICU). The Intensive Care Society classifies patients' level of need based on their acuity. The unit can be staffed and equipped flexibly to meet the needs of patients, which means the numbers of patients requiring different levels of care can be changed responsively. The two units are staffed by a single team are equipped with 23 beds in a combination of four-bedded bays, two-bedded bays and individual side rooms that can be used to isolate infectious patients. The HDU has two four-bedded bays and three side rooms and the ICU has two two-bedded bays and eight side rooms. The CCC can care for up to 12 patients who are ventilated at the same time.

The ICU is a purpose-built unit and side rooms have negative pressure capability and staff are able to adjust environmental controls such as the temperature. The HDU was converted from a progressive care unit in July 2015. The CCC is accessible by swipe-card access only, which ensures only authorised visitors are allowed into the clinical area.

Between April 2015 and March 2016 the CCC cared for 760 patients, with occupancy rates between 60% and 100%. Overall 44% were admitted directly from a hospital ward, 35% were emergency unplanned admissions and 13% were elective admissions. At the time of our inspection six beds were closed while the service awaited an increase in

staffing levels to safely provide critical care services to full capacity. The CCC contributes to local and national audits with the support of a clinical audit lead and two audit nurses.

During the inspection we spoke with 67 members of staff, including doctors and nurses of all grades, therapies staff, healthcare assistants, clinical and non-clinical support staff and managers, a clinical director, a managing director, the director of human resources and the head of nursing. We also spoke with 10 patients and five relatives, looked at the standard of nursing and medical records for 20 patients. Following our announced inspection we returned to critical care for an unannounced inspection and spoke with a further nine members of clinical and non-clinical staff.

We previously inspected medical care services at North Middlesex University Hospital in August 2014. During that inspection, we rated critical care services as good overall.

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Summary of findings

We rated this service as requires improvement because:

- There was inconsistent learning and evidence of change management from clinical incidents. There was also limited evidence of learning or improvement following audits, complaints, patient feedback and morbidity and mortality meetings.
- We found good infection prevention and control audit practices were in place but staff practice during our inspection did not always reflect this.
- Nurse staffing levels could be unpredictable and did not always meet national guidance. Safety checks on agency nurses were inconsistent and poorly managed.
- Levels of mandatory training did not meet the trust's minimum target.
- Multidisciplinary team working was of a high standard but low levels of staffing meant the unit could not meet the requirements of the National Institute of Health and Care Excellence (NICE) in relation to the rehabilitation of patients.
- Patients and relatives had provided consistent feedback on variable communication and involvement by clinical staff. This included a lack of consistency between nurses and occasions where they felt staff were unfriendly and unapproachable.
- There were limited resources on the unit for patients with dementia or learning disability. Staff knowledge was variable, including amongst nurses in relation to consent and mental capacity.
- Out of hours discharges were significantly higher than the national average and clinicians actively tried to avoid discharging patients at a weekend due to short staffing on inpatient wards.
- Staff morale was variable and we received a number of complaints about bullying and victimisation. We saw little evidence the senior team had taken appropriate action to address these concerns and staff we spoke with told us they lacked confidence in the trust's human resources department.

However:

- Care and treatment was consultant led and medical staffing levels met national best practice guidance.

- Medicines management was of a high standard, with consistent input and safety oversight from a dedicated pharmacist.
- Staff used the national guidance of a number of organisations to benchmark their practice and to ensure care and treatment was safe.
- A new practice development nurse was in post, which would significantly improve oversight of staff training and competency checks.
- New training had been provided to staff in the care of patients with dementia and in communication skills. Both programmes were implemented in response to patient and relative feedback and aimed to improve quality of service.
- Rates of delayed discharges were significantly lower than the national average.
- The senior team had a clear vision and strategy for the unit and its staff team for 2016/17, which addressed staff turnover and skill mix.

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Are critical care services safe?

Requires improvement 

We rated safe as requires improvement because:

- Incident-reporting processes were well established and there was evidence incidents were investigated appropriately. However, not all staff had access to the reporting system and overall the team demonstrated variable knowledge of the outcomes of incident investigations, including a senior clinician who did not know there had been a serious incident in the previous year. This meant dissemination processes were not robust although detailed outcomes of serious incident investigations were on display in the nurse staff room.
- Staff used the national early warning scores system to monitor deteriorating patients and to escalate their care when needed. Daily safety checklists were in place and staff used these to identify patients whose condition had changed or was cause for concern. This tool was used variably and sometimes inconsistently.
- Consultant led monthly morbidity and mortality meetings were held to investigate any possible learning from patient deaths. There was limited evidence this learning was widely circulated and in 26 out of 36 records, there was no learning identified.
- A safer staffing tool was used to ensure nurse to patient ratio met the requirements of the Intensive Care Society (ICS) core standards for intensive care. This was inconsistently applied and there was room for improvement in how shift leaders used this information. In addition, senior staff did not always apply consistent and robust induction and safety check processes to agency nurses new to the unit.
- Procedures were in place to ensure staff could report faulty equipment and medical technicians were available 24-hours, seven days a week. There was variable evidence staff used this system in practice, including a number of items of faulty equipment on the unit with undated hand-written notes advising they were faulty.
- Regulations regarding the control of substances hazardous to health were not always followed, such as in the safe storage of chlorine tablets.

- Discharge documentation we looked at was of a high standard but care plans were often illegible. There was no system in place to track improvements in documentation following the audit
- Safeguarding knowledge amongst nurses was highly variable and none of the nurses we spoke with could give an example of when they had used the trust safeguarding policy or who the lead safeguarding nurse was in the hospital.
- Staff knowledge of fire procedures and evacuation protocols was variable. A fire risk assessment was conducted after our inspection and found the unit did not have named fire wardens, staff were not trained in evacuation procedures and doctors had no routine fire safety updates. There was no associated action plan with the assessment.

However:

- Care was led by consultant intensivists and cover was provided that met the requirements of the Faculty of Intensive Care Medicine and the ICS. Trainee doctors received structured support and locum doctors undertook an induction process that was fit for purpose.
- Both electronic and paper-based records systems were in place for patient notes and observations. A nurse-led audit found a good overall standard of notes and identified areas for improvement, including those also highlighted in feedback from ward staff.
- Knowledge and practice of the principles of safeguarding were consistently good amongst the medical team, healthcare assistants and ward clerks.
- Staff received mandatory training in 10 key areas and overall 76% of the unit team were up to date with their training.

Incidents

- The trust used an electronic reporting system for the submission of incidents. Between June 2015 and August 2016, staff in critical care reported 466 incidents.
- There were no never events reported. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- All of the unit staff we spoke with except for healthcare assistants (HCAs) said they had training on the use of the

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reporting system and felt confident in its use. However, some staff told us it was common practice not to report incidents because they did not have time on shifts to complete reports. As a result, they felt the senior team were not aware of all of the incidents on the unit. We asked the clinical lead and the matron about this who said incident reporting rates in critical care were some of the highest in the whole trust and they felt the system worked well.

- HCAs did not have access to the incident reporting system, despite working clinically with patients. HCAs told us they would approach a senior member of staff to submit an incident report if needed. However, there was a lack of evidence HCAs had a robust knowledge of events that should be reported as an incident and no-one in the team could tell us about a recent incident or outcome.
- Staff told us they felt incidents were investigated variably. For example, one member of staff said investigations were much more thorough and lacked confidentiality if the person involved was in dispute with the senior team. They said, "It is not a 'no blame' culture. You're very much blamed if you're not one of the friends of the senior team. If you are, there is a brief investigation and you get on with [your job]. If you are not a personal friend of the senior team, you are suspended and the investigation is very traumatic." Four other members of staff said they felt incident investigations were fair and appropriate although could not give any recent examples.
- A multidisciplinary team reviewed incidents submitted on a weekly basis. This process was used to assign an appropriate investigator to each incident, to establish the action to be taken and to identify lessons from the incident. Senior staff demonstrated a proactive approach to investigating incidents and minimising risk to patients and staff. For example, a tissue viability nurse was involved in all incidents where a patient had a pressure ulcer and senior staff followed hospital policy after a nurse experienced a needlestick injury. Despite this process, some clinical staff were unaware of learning or actions from incidents, including serious incidents. A folder on the unit contained minutes of the weekly meetings until April 2016. We asked a member of staff where they would find more recent information from meetings and they were unable to tell us.
- A consultant led monthly morbidity and mortality (M & M) meetings, which were used to review patient deaths

and outcomes. This included consideration of a number of factors in patient care, including whether they had an advanced care plan and whether staff had discussed end of life care with their relatives. Other consultants were able to contribute or add comments to the planned discussion about each case in advance of the meetings. Doctors from other specialties in the hospital regularly contributed to the meetings and there was evidence findings were used to improve patient care. For example, a consultant was working with colleagues in accident and emergency to ensure problems encountered before admission were communicated between clinicians more effectively.

- The latest available information from M & M meetings supplied to us was from March 2016 and April 2016, which included 36 patient deaths. Each M & M record included space to record learning. Eight records indicated a need for improved documentation, including discharge notes and death certificates. One record indicated better communication was needed between shift teams on the unit and in 26 records there was no learning point identified.
- In the two years prior to our inspection, the critical care complex (CCC) reported two serious incidents according to the National Patient Safety Agency National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (2010) and NHS England's Serious Incident Framework (March 2013). The staff team demonstrated variable knowledge of the incidents, their investigations and outcomes. Two clinicians and five nurses said they did not know there had been any serious incidents. Both incidents resulted in a patient death and senior staff established action plans to reduce the risk of similar incidents in the future. All action points for one serious incident were recorded as completed although there was limited evidence they had all taken place in practice. For example, one action point was to implement a robust incident reporting system but not all staff had access to this. Of the eight action points assigned to the second serious incident, four were delayed by over five months. All four related to the unit's ability to provide care and treatment to patients with a learning disability and/or dysphagia. There were no documented updates to this since April 2016.
- Information about the investigations of serious incidents, their outcomes and changes in practice were displayed in the staff room. This included a patient who

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had been left alone when under 1:1 nursing care and later died after experiencing a cardiac arrest. The root cause analysis identified a number of contributing factors, including poor training and support to staff, a lack of team working, a disinclination to escalate incidents within the ICU and a failure of staff to accept collective responsibility when things went wrong. A second serious incident outcome identified the need for better coordination with community teams when a patient was admitted, particularly the speech and language therapy (SaLT) team. The clinical lead for SaLT formed part of the multidisciplinary investigation, which identified a need for better staff training, a hospital policy on the treatment of patients with dysphagia in the ICU and more detailed attention to the needs of patients with a learning disability. There was limited evidence the identified improvements had been implemented. For example, a section that required staff to identify patients with learning disabilities on the daily safety checklist had been introduced. However, the printed hospital policies available to staff on the unit did not include guidance for treating patients with dysphagia or a swallowing problem and staff we spoke with said they were not aware of a policy on the intranet.

- A system was in place to respond to a serious incident. This involved allocation of responsibility for the investigation within 48 hours of it being reported along with an immediate review by the head of nursing and medical director. Serious incidents were added to the service risk register and the action plan was monitored monthly during a risk and governance meeting.

Safety thermometer

- Staff in the unit contributed to the NHS Safety Thermometer programme although this was not displayed publicly or for staff.
- No falls with harm were reported to the safety thermometer between June 2015 and June 2016. One new pressure ulcer and two urinary tract infections in patients with a catheter were reported over the same period. Staff used care bundles and prevention pathways to avoid both conditions, which we saw in use.

Cleanliness, infection control and hygiene

- Between April 2015 and June 2016, there were no cases of unit-acquired MRSA and nine cases of hospital-acquired *Clostridium difficile* (C.Diff).
- Staff conducted monthly audits of high impact interventions in line with Department of Health Saving Lives infection control guidance. This included monitoring of practice and standards in hand hygiene, peripheral venous catheter and urinary catheter management and monitoring of C.Diff infection. Between April 2016 and June 2016, the CCC achieved 100% compliance with C.Diff infection control standards, with three weeks in this period where data were not available. During the same period the unit achieved 100% compliance with infection control care standards in peripheral venous cannula insertion and management. Between April 2015 and March 2016, the unit achieved 100% compliance with the trust's urinary catheter care bundle.
- The unit had a good track record of hand hygiene standards, with a 100% achievement of trust standards between March 2015 and March 2016, except in four weeks where data was not available. However, during our inspection not all staff adhered to good infection control principles or hospital policy consistently. For example, one clinical member of staff did not observe the 'bare below the elbows' policy and we observed three clinical members of staff enter the unit without washing their hands or using alcohol gel. In the high dependency unit (HDU) we observed nurses entering and leaving bed bays and interacting with patients without washing their hands afterwards. During our unannounced inspection we observed one member of staff exit a patient's side room wearing a hooded jacket and without their sleeves fully rolled up.
- There was room for improvement in the cleaning standards of some areas. The staff room was visibly dirty, with food debris visible on the floor, a dirty fridge used to store staff drinks and very dirty food preparation areas.
- Treatment areas and side rooms were clean and tidy and cleaning staff followed weekly and daily cleaning checklists to ensure all areas received appropriate attention. This included a weekly clean of high-level surfaces. During our unannounced inspection we found faecal soiling on one pan used for patients at their bedside, although it was labelled as clean. This meant processes to ensure cleaning was thorough and protected people from harm were not always followed.

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- There was not a clear support structure for all non-clinical staff in the unit to help them manage infection risks to patients. For example, we saw a senior nurse challenge a catering member of staff in the unit who was observed entering side rooms with infection risks without wearing personal protective equipment (PPE). Although the nurse told the member of staff to wear an apron, they did not know where to find this and could not demonstrate a clear understanding of the principles of infection control.
- Doctors observed good infection control practice during ward rounds we observed.
- Infection prevention and control was part of the trust's mandatory training programme, with all staff required to undertake an annual update. Overall in critical care, 75% of staff were up to date with this training.

Environment and equipment

- A team of HCAs were responsible for stock rotation of consumables, ordering new supplies and ensuring treatment trollies were stocked.
- The environment complied with the Department of Health (DH) Health Building Note (HBN) 00-09, infection control in the built environment. This meant the unit's design and construction meant care and treatment could be provided in an environment that, when properly managed, ensured infection prevention and control and good hygiene practices protected patients from harm. The unit also complied with DH HBN 00-10, design for flooring, walls, ceilings, sanitary ware and windows. This meant the environment was designed in a way that meant care and treatment could be provided safely and in line with national requirements.
- Staff told us they found it difficult to maintain the temperature in the HDU. We saw this had an impact on patients. For example, one patient needed a cool bed bath during the night when the unit was so hot they could not stop sweating. To address this staff had opened windows on the unit. However, a patient with a form of pneumonia was present and staff had not considered the risk this presented to them.
- A dirty utility cupboard on the unit was unlocked and was used to store chlorine tablets and eight bottles of expired surgical scrub fluid. Three containers of expired urinalysis strips were also stored here. Chlorine tablets are toxic and should be stored in accordance with the control of substances hazardous to health guidance,

including in a locked cupboard. We asked two nurses in the area about this but they did not know who was responsible for disposing of expired stock or if the products were still being used.

- A system to manage faulty equipment was in place, including standardised documentation and communication protocols to contact equipment technicians. Ward clerks were able to report items Monday to Friday and at weekends on-call technicians were available for urgent problems. However, we did not see staff use this system consistently. For example, one item of medical equipment had a hand-written note attached that instructed staff to leave it switched on until Friday due to a communication error. The note was undated and unsigned, which meant it was not possible to find out what the problem was or why it should be left switched on. Four other items of equipment with hand-written notes regarding faults were discarded around the unit. All staff we spoke with were aware of the procedure for contacting technicians and so it was not clear why this was not followed when reporting faulty items. An incident report had been submitted regarding an item that had been faulty for four weeks. The outcome indicated a new log of faulty equipment would be created on the unit and there was no indication of improved training for staff on the use of the existing procedure.
- A microwave in the staff room had a hand written notice on it that stated it should not be used due to a faulty fuse. Staff were not able to tell us if this had been reported or why it was still in situ. A fire safety risk assessment highlighted three items of electrical equipment, including this microwave, supplied by staff that had not undergone a portable appliance testing safety check.
- Staff documented regular checks of the resuscitation and difficult airway trollies and emergency transfer equipment.

Medicines

- A pharmacist attended the weekly multidisciplinary meeting and was involved in investigations of incidents that involved medicines management and provided teaching to unit staff. Pharmacy staff identified their main challenges in the unit as the inconsistent locking of the drugs cupboard, drugs prescribed with no times and gaps in the administration of oxygen when changing masks for nasal cannula.

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- Senior staff used a medication safety cross system to categorise medication errors and incidents by level of severity, which meant they could be prioritised for investigation and resolution. The incidents were reviewed on a weekly basis by the critical care pharmacist according to whether the error was related to prescribing, administration, dispensing or storage. The system was effective in ensuring action plans were formed and learning took place from incidents and problems. However, how this was communicated to staff and how new systems and processes were implemented was not always clear. For example, one medication safety cross bulletin in September 2016 identified a need for the drug cupboards to be kept locked for security and safety. Although shift leaders ensured this took place, we observed staff on several occasions unable to locate who had the keys to access the cupboard. Staff in the intensive care unit (ICU) put in place a new system whereby a large cut-out sign of a key was displayed on the side room door where the key-holding member of staff was assigned to work. However, during our unannounced inspection we saw staff did not use this system and staff did not always know who held the keys or where to find them.
- Medicines were stored securely and appropriately, including those requiring refrigeration. Regular expiry date checks were in place and there were suitable arrangements for ensuring medicines were available out of hours.
- We were told that the POD (patients' own drug) lockers in use were not large enough for the medicines stored and, although we did not see any medicines stored incorrectly, the weekly audit of medicines on the ward (medication safety cross) noted occasions when medicines were stored outside of these lockers and not locked away.
- Controlled drugs (CDs) were stored and managed appropriately. The CDs were checked twice a day by two registered nurses. Strong potassium chloride solutions were kept within a separate CD cabinet as per trust policy.
- Emergency medicines and equipment were available and checked twice daily in line with the policy, and a complete check was done monthly or when used.
- A clinical pharmacist visited the ward daily and attended ward rounds. They were available during the rest of the day for medicines supply and advice via a bleep.
- Prescriptions were clearly written and separate infusion charts were in use which contained pre-printed information to support safe prescribing and administration.
- Staff told us how learning from incidents was passed down through their 'cobra' meetings and handovers. We saw that this had taken place when the new intravenous potassium products were stocked.

Records

- Staff in the unit used different systems to record patient observations and treatment. Doctors and dietitians used an electronic recording system and nurses used a paper-based system, with multidisciplinary staff using both systems. This resulted in duplication of work or inconsistent practices where one member of staff would use both systems and another would use only one system. There was also a lack of computer terminals that meant staff could not always enter information into patient records immediately. Separate electronic systems were used to record the results of investigations and to monitor bed management. The electronic systems worked independently of each other, which meant it was time-consuming for staff to review patient notes and observations. Doctors told us they had adapted to this system and did not feel it impacted on patient safety or quality of care.
- A nurse had conducted an audit of the quality of patient records in the unit. This found 78% were of a 'good' standard, including patient details fully completed and clear tracking of observations. The audit identified room for improvement in the completion of patient date of birth and name and in the use of nurse stamps or clear nurse signatures.
- Daily safety documentation from nurse handovers indicated colleagues elsewhere in the hospital had raised concerns about the standard of patient records in critical care. This included gaps in information sent to the bereavement office and the quality of discharge documentation sent to medical inpatient wards with patients. The senior team had addressed this in part by ensuring two members of staff prepared documentation for patients with pressure ulcers, with a final check by the nurse in charge. This meant ward staff received more accurate and complete information when they

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admitted a patient from critical care. We looked at discharge plans during our inspection and found in all cases they were written by a consultant and were detailed and fit for purpose.

- Staff completed a number of risk assessments shortly after admission in line with national guidance. This included a waterlow score, risk assessments for bed rails, falls, moving and handling, intravenous access, venous thromboembolism and the malnutrition universal screening tool. Each patient also had a pressure ulcer risk assessment using the five step 'SSKIN' care bundle.
- The evaluation section of five care plans we looked at were almost completely illegible due to the poor quality of handwriting. This had been identified as an area for improvement in a local audit but there was no evidence this had improved.
- The critical care outreach team completed observational documentation according to the vital signs recording and reporting policy. This was filed in patient notes on wards and ensured nurses had access to up to date monitoring of patients using the national early warning scores (NEWS) system.

Safeguarding

- Three safeguarding incidents were reported between June 2015 and August 2015. In all cases staff demonstrated rapid and appropriate action to ensure patient welfare was maintained, including liaison with local authority crisis teams and the police.
- Clinical staff demonstrated variable understanding of the principles of safeguarding during a ward round. For example, a consultant highlighted the need for a safeguarding discussion about a patient who had no known next of kin, including consideration of the need for an independent mental capacity advocate (IMCA). However, the nurse responsible for the patient demonstrated a low level of knowledge in relation to safeguarding and was unaware of the role of an IMCA or why this might benefit the patient.
- Resources for staff on the unit were not detailed or readily available. A safeguarding folder on the ICU contained information irrelevant to safeguarding. Staff said they would refer to the intranet for safeguarding policies but said they had not previously done so.

- Safeguarding training was a mandatory element of the induction process for all staff and was refreshed on an annual basis. The practice development nurse supplemented the trust's safeguarding training with study days tailored to patient needs in the unit.
- Staff were required to complete safeguarding training to a level relevant to their role and level of clinical responsibility and included adult safeguarding levels one and two and child safeguarding levels one and two. Overall, an average of 77% of staff had up to date training, with only 50% of staff who required adult safeguarding level two up to date.

Mandatory training

- The trust provided a core package of mandatory training for all staff, regardless of role, on starting their role. This consisted of 10 training subjects delivered through a mix of self-directed electronic learning and classroom-based practical training. Subjects included fire safety, information governance, infection prevention and control, moving and handling and basic life support.
- Staff were provided with refresher training in line with legal requirements for each subject and the trust had an 90% minimum target for the completion of this. The CCC team did not meet this target as 76% of staff were up to date with training. This followed a period in which there was no lead practice development nurse in post and some staff told us they felt pressured to come into the hospital on their days off to complete training, which they said they were not paid for. Senior staff in the unit told us staff were always paid for training but we were not able to confirm which account occurred in practice.

Assessing and responding to patient risk

- The nurse in charge used a daily safety checklist and briefing document to identify patients with complex or unusual needs. This included a record of concerns raised by staff where they felt their ability to meet patient's individual needs might be affected, including through short staffing. The safety briefing documents were not used consistently and there were seven days when no documentation was available in the month prior to our unannounced inspection. Although staff used this system to record concerns, there was not a robust system to ensure a senior member of the team investigated or resolved these. For example, on one date a member of staff had written that three patients had grade two pressure ulcers, and instructed staff to

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turn patients regularly. There were also three separate entries describing concerns about how many patients were “agitated” but a clear plan of action or investigation into the cause had not been documented. In one case a member of staff had written, “Please pay more attention.” This meant risks to patients was not always clearly managed because systems and processes were not in place that ensured staff concerns were followed up and resolved.

- Staff used the national early warning system (NEWS) tool to monitor patients’ condition and to identify patients who were deteriorating. A critical care outreach team provided 24-hour support to ward staff in the safe use of NEWS.
- Evidence that clinical examinations took place in a timely manner was inconsistent. In one set of notes we found documentation of a physical examination related to a deteriorating neurological condition was incomplete and a very brief overview was recorded one day after the examination had taken place.
- All staff in the unit were required to undertake basic life support training and all nurses were required to undertake intermediate life support training. All critical care outreach team (CCOT) nurses and senior nurses were required to complete advanced life support training. Overall 79% of staff were up to date with life support training.
- Three clinicians planned an audit in 2016/17 to assess the response of each hospital area to deteriorating patients and to ensure staff escalated patients appropriately. This audit would be used to benchmark overall care of deteriorating patients according to Faculty of Intensive Care Medicine and Intensive Care Society (ICS) standards.

Nursing staffing

- Between April 2016 and June 2016, the CCC was understaffed by an average of 12 whole time equivalent nurses and healthcare support workers per month. This was worse than the period between April 2015 and March 2016 when the unit was understaffed by an average of 0.5 whole time equivalent of a nurse per month.
- Senior staff used the safer staffing gold standard tool to help them establish the minimum safe number of nurses needed per shift according to ICS standards. This standard requires a nurse to patient ratio of 1:1 for those receiving level three care and a nurse to patient ratio of

1:2 for those receiving level two care. We observed the tool was used appropriately but staff did not always understand the results. During our unannounced inspection we found one nurse was responsible for two level two patients and one level one patient. The guidance of the ICS state that the nurse to patient ratio for level two patients can be 1:2 but the nurse must not be additionally responsible for other patients. We asked the nurse in charge about this but they had been unaware that a nurse had been allocated three patients on their shift. We asked if this would be reflected in the safer staffing clinical governance data, which they could not confirm.

- Nurses in the HDU were not always allocated to patients in a way that ensured their safety. This was because nurses could be allocated patients in both individual side rooms and in one of the four-bedded bays. This meant they had to move between the beds constantly to supervise their patients and there were periods when no member of staff could see patients in side rooms. This had an impact on other safety considerations in the unit. For example, a notice on a side room instructed staff to keep the door closed at all times. This was to prevent the risk of infection from a patient being cared for in the room. However, the nurse responsible for this patient left the door open as they had another patient to care for in a bed bay. We asked the nurse in charge about this. They said nurses often left doors open as it was the only way for staff to be able to see into the room when they were also allocated to work elsewhere. This meant the risk of cross-infection between patients was increased. We spoke with a nurse who was allocated to caring for patients in two separate areas. They said, “This happens quite often. We have raised it with [senior staff] but we didn’t get any feedback or explanation.”
- We asked 10 patients and relatives about staffing levels. In all cases we were told they felt the number of staff on shift was enough but every person commented on the lack of consistency between staff. One patient said, “I have been here for over a week now and every shift I get a different nurse. Most of them are nice but I wish sometimes I would see the same face more than once, it helps to get to know someone.”
- Nurses did not always have the skills, knowledge or experience to identify or challenge the practice of others. This meant there was not a system of peer

Critical care

review or cross-checking of practice in place. For example, seven nurses we spoke with said they did not feel confident enough to ask questions of doctors about practice that concerned them.

- Nurse handovers took place twice daily. One handover we observed was well organised and included all of the staff on shift that day. The nurse in charge conducted a safety briefing and asked staff if they had any concerns or questions as part of a new “have your say” initiative. The nurse in charge also reviewed all patients with elevated risks, such as those at risk of falls or pressure ulcers. This approach was applied inconsistently and did not take place in a nurse handover we observed during our unannounced inspection. At this handover three staff nurses and a nurse in charge arrived late and there was variable engagement of staff from the senior nurses. Allocation of staff nurses to patients was completed without demonstrable interaction with them to find out if they had previous experience with specific patients or needed support in relation to caring for patients with complex needs. There was a variable approach to detail and accuracy during our observations of bedside handovers between nurses. During one handover a nurse noticed they had not recorded updates to an observation chart and did this retrospectively. However, during another observation nurses handled an error in the recording of medication appropriately and ensured this was rectified.
- A team of 10 HCAs provided support to nurses and care to patients. During a typical shift two HCAs were assigned to the ICU and one HCA was assigned to the HDU. HCA duties included turning patients to prevent pressure ulcers and providing personal care.
- Agency nurses were employed to address the short fall in permanent nurses. Senior staff conducted a brief induction for each agency nurse to ensure they could work safely on the unit, including a check they understood local escalation policies, emergency contact details and the location of essential equipment. Checks were documented and stored on the unit according to an orientation checklist, which the nurse in charge was required to countersign. We looked at six examples of orientation checklists within a two-month period prior to our inspection. Records were inconsistent and where a lack of knowledge was indicated by the agency nurse, there were no comments or documented corrective action from the nurse in charge. For example, one question asked the agency

nurse to confirm they had read and understood and were familiar with a medicines management folder provided with the orientation form. One agency nurse had written “NO” in response to this but the nurse in charge had still signed their documentation to indicate they were safe and competent to work in the unit. On another orientation form, the agency nurse had indicated they were not familiar with the unit’s patient observation documentation. There was no indication the nurse in charge had responded to this.

- There was a broad lack of understanding amongst nurses and HCAs with regards to lines of responsibility. For example, a new deputy matron had been appointed but there was no clear definition of their role and none of the staff we spoke with could explain this. Six nurses and HCAs we spoke with said they did not understand the role of band seven nurses and felt there was a vacuum of leadership around this. For example, they said they did not understand what the band seven role entailed because this team no longer took responsibility for patient care, even when staff nurses were struggling with their workload. We asked the matron about this. They told us the band seven team organised the rota, managed sickness reviews, managed incidents and led on audits. Additional responsibilities included infection control, risk assessments, medical devices and documentation. However, there was no evidence of quality monitoring of the processes and responsibilities in the additional roles as we found areas for improvement and a lack of staff awareness with regards to a number of these areas, including infection control and medical devices.
- Between July 2015 and July 2016, an average of 14% of the budget for nurse staffing was spent on bank and agency staff and high rates of nurse sickness were documented as concerns by the senior management team in meetings from May 2016 and July 2016.
- Between June 2015 and August 2016, 38 incidents were reported in relation to short staffing. In each case there was evidence the bed manager, site manager or another senior member of staff was informed but there was no evidence this concern was addressed directly with nursing teams. In one case, the responsible person for the incident noted that new staff to the unit would “see a change in the coming months.” The action from each incident did not indicate how risk was mitigated.

Medical staffing

Critical care

- A team of eight consultants led care and treatment in the CCC. This team consisted of six ICU consultants, four of whom were dual-trained anaesthetists, and two intensivists. Seven members of the team were accredited by the Faculty of Intensive Care Medicine (FICM) and one consultant held the European diploma in intensive care medicine. Consultant cover was provided in the ICU from 8am to 9pm and in the HDU from 8am to 6pm, seven days a week. Out of hours, a consultant was always available on-call and could reach the unit within 30 minutes. All patients received a consultant-led admission that took place within four hours of the decision to admit. A consultant-led review took place within 12 hours of admission. This meant the unit met the requirements of FICM and ICS core standards for intensive care units. Consultants were supported by a team of senior house officers, specialist registrars and trainee doctors.
- Consultant-led medical handovers took place twice daily. The nurse in charge from both the ICU and the HDU, a critical care outreach nurse, the medical team and multidisciplinary care team attended the handovers. We observed a high standard of communication between the clinical team and the multidisciplinary team that included excellent management support from the consultant to the registrars and trainee doctors. Trainee doctors also presented patients whose condition had changed overnight including a review of x-rays and scans.
- Consultant-led ward rounds took place twice daily. We observed a ward round and found it to be unstructured and with room for improvement in communication between staff. For example, the consultant did not formally present or examine all patients, the bedside nurse was absent for most of the discussion of the first patient and there was little evidence of instruction or support to junior doctors. The nurse in charge was present intermittently as was frequently interrupted by more junior nurses who needed support and junior doctors frequently left the bedside area during discussions. At the end of the ward round, staff completed a safety checklist to ensure essential risk assessments had been completed, including for VTE, safeguarding, staffing levels planned discharges or transfers. This represented good practice and ensured all members of staff were fully briefed on the plan for each patient.

- Trainee doctors received a hospital and local induction as well as weekly protected study time. Induction information for locum doctors was up to date and available on the unit.
- Between July 2015 and July 2016, an average of 20% of the budget for medical staffing was spent on locum or temporary staff.

Major incident awareness and training

- Major incident plan and business continuity documentation and policies were up to date and stored on the unit.
- Staff had variable knowledge of what to do in a fire, major incident or evacuation. One member of staff said, "I was told this morning there is a new fire policy. I don't know what it is; I haven't had time to read it yet." Not all staff working on the unit knew who would be responsible in the event of a fire or evacuation. On one day of our inspection, a mobile phone was being charged while stored underneath a pile of clean linen. This represented a fire risk and meant the member of staff who placed it there was unaware of the risk.
- The unit's most recent fire risk assessment was conducted in September 2016. The risk assessment found the overall risk status of the unit to be low and found a number of areas in which improvements were needed. For example, the assessment found no staff had been given the opportunity for specialised evacuation training and there were no records that a fire evacuation drill had taken place. In addition, there were no fire wardens in post and the assessment highlighted that doctors and consultants were not included in routine fire safety reviews or training. This risk assessment took place after our inspection and did not include a timeline for the required improvements.

Are critical care services effective?

Good



We rated effective as good because:

- A programme of local audits was used to drive improvements in care and was supported by a lead clinician and two audit nurses. The audits were benchmarked against national best practice guidance from appropriate organisations.

Critical care

- Although the unit had not fully implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015), patients felt their pain was managed well. We found inconsistent documentation of pain management and this was identified in the unit's development strategy for the coming year.
- A dedicated dietitian worked with staff and patients to ensure individual nutrition plans met each patient's needs.
- Established protocols and appropriate staff training was in place to ensure patients were discharged and transferred safely.
- Unplanned readmission rates within 48 hours of discharge were better than the national average.
- Consultants and the critical care outreach team provided teaching and learning sessions during bedside handovers and through study days. Staff spoke highly of these and said they helped to develop their skills with conditions they were not experienced in treating. A new practice development nurse was in post and was supported by two practice educators. This team had begun to develop support for nursing staff in updating their clinical competencies and ensuring new nurses received appropriate educational support.
- A dedicated and highly committed multidisciplinary team provided support to the critical care complex. This included physiotherapists, a pharmacist and a dietitian.
- Consultant cover was provided 24-hours, seven days a week.
- Although multidisciplinary input and support was available to patients, the level of cover available did not meet clinical guidance 83 of the National Institute for Health and Care Excellence, including no provision for occupational therapy.
- A new delirium policy was in the process of being implemented but staff demonstrated variable knowledge of mental capacity and consent.

Evidence-based care and treatment

- Care and treatment was provided in line with national and international best practice guidance, including in the use of the aseptic non-touch technique and antibiotic therapy. Doctors used criteria endorsed by the European Society of Intensive Care Medicine, the Society of Critical Care Medicine and the American Thoracic Society when providing treatment for acute respiratory distress syndrome. Other local policies were based on the guidance of the National Institute for Health and Care Excellence (NICE), the Intensive Care Society (ICS) and the Faculty of Intensive Care Medicine (FICM). This included policies for the containment of infection, managing delirium and managing airways.
- Nurses were encouraged to lead their own audits, based on their clinical competencies and areas of interest. The results of such audits were displayed in the staff room for colleagues to learn from. This included audits in pressure ulcer prevention, effective record-keeping, effective use of nasogastric tubes and supporting patients with oral hygiene.
- A locum doctor was the lead clinician for audits, including local and national audits and was supported by two audit nurses. Work had begun to involve nurses and clinical fellows in audit programmes. This member of staff represented the unit at the hospital audit committee to ensure audits contributed to service development and were in line with hospital quality standards. The audit team had established a plan of 13 audits for 2016/17. Twelve audits were benchmarked against national standards of practice set by FICM, the ICS, NICE or the Resuscitation Council. This meant the results could be compared with other critical care units, used to recognise good work and to improve services. One audit was planned collaboratively with the emergency department to audit referral and transfer procedures.
- A team of nurses had conducted an audit of sepsis knowledge in July 2016 against a minimum standard of

However:

- The unit did not meet the requirement of the Royal College of Nursing that 50% of nurses have a post qualification in intensive care medicine. We were told this was due to changes in the education team and a reconfiguration of the unit. However, 23 course places had been supplied and the unit would exceed the 50% target in April 2017.
- An audit highlighted low levels of knowledge and understanding amongst staff of sepsis diagnosis and treatment. This audit led to study days being offered but no follow-up had been conducted to ensure they had been effective.
- Staff described difficulty in obtaining appropriate food from the catering supplier and patients did not have access to meals after 5pm.

Critical care

70% across eight standards including understanding of sepsis and severe sepsis and knowledge of the Sepsis 6 bundle. The audit found very low levels of knowledge of sepsis amongst critical care staff. For example, only 30% of staff understood what sepsis was, 19% could describe the Sepsis 6 bundle and only 37% of staff knew who the trust's sepsis lead was. The results of this audit indicated patients with sepsis were at significant risk of delayed or inappropriate care due to a lack of staff competence. To address this, sepsis study days had been offered and a re-audit of staff knowledge was planned. However, the results of this audit were not widely disseminated and the audit lead was unaware of it initially although 37% of all patients admitted between April 2015 and March 2016 were diagnosed with sepsis.

- The critical care outreach team (CCOT) had a programme of audits used to drive improvements in the quality of patient care and governance. This included a monthly audit of the use of the national early warning scores (NEWS) system on inpatient wards and audits on staff response time to cardiac arrests and night time activity.

Pain relief

- The unit had not implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015). Staff did not consistently record pain scores or reviews. In five sets of notes we looked at, pain was not documented regularly in three cases. The 24 hour observation chart used by staff for each patient did not include a section to record pain scores, which meant they had to write this on a spare line on the chart. This contributed to the lack of consistency in recording we found.
- All of the patients we spoke with said they felt their pain relief was managed appropriately.
- An acute pain team was available and provided care to patients who were prescribed patient-controlled epidural analgesia and sickle-cell trait.
- Senior staff had identified better pain management as a priority for the unit in the next business year.

Nutrition and hydration

- A dietitian was available in the unit and attended ward rounds where necessary. This member of staff prepared individual nutrition plans and ensured malnutrition and dehydration was avoided.

- Clinical staff described difficulty in ensuring patients received food in a timely manner. This was because meals had to be heated in the unit's kitchen, which did not have adequate capacity for the number of patients. Staff said this often resulted in lengthy delays in patients receiving meals and used the incident reporting system to escalate this. The outcome of two incidents whereby a patient did not receive their ordered meal indicated the matron had asked the catering manager to investigate but there was no learning or action plan documented to ensure this did not recur.
- We spoke with six patients about food and drinks on the unit. Four patients said portion sizes were small and they still felt hungry after each meal. They also said there was no food available between 5pm and breakfast the next morning, which meant they were often very hungry in the morning. One patient said, "The nurses will find some tinned fruit or a biscuit if you ask them but there's no way to order food after 5pm." Most patients described the quality of food as "okay" and one person said, "It's bland and tasteless but at least there is some fruit available." One patient said they were very happy with the choice and quality of food.

Patient outcomes

- Of the patients admitted to the unit between April 2015 and March 2016, 78% survived. This represented a mortality rate of 22%, which was slightly worse than the national average of 18%.
- Unplanned readmission rates within 48 hours of discharge were better than the national average. Three patients were readmitted to critical care within 48 hours of discharge between April 2015 and March 2016. This represented 0.6% of all patients, compared with the national average of 1.1%.
- The unit did not have a protocol for weaning patients and we received variable comments from staff on this. Some multidisciplinary (MDT) staff told us weaning was difficult due to the lack of trained staff, established protocols and variable standards of communication. For example, one member of the MDT team said the clinical team did not often consult other specialists to ensure weaning was successful, which put patients at risk. Another member of staff said a trial had begun in critical care using equipment that would change the way they could provide care to patients but they had not been informed about this.

Critical care

- The CCOT team reviewed every patient after they were discharged to a ward. This ensured patients received care and treatment according to the consultant's plan and also provided some continuity for them between critical care and a medical ward.
- A consultant lead for transfer was in post and was supported by a team of senior nurses who had completed transfer training and competency checks. A transfer policy was in place and was under review and a further ten nurses were scheduled to complete training in this. Two doctors had audited this process in May 2016 and found the process and associated all-day training session with a live ambulance to result in improved safety and outcomes for patients.

Competent staff

- Senior nurses and the matron were responsible for ensuring each nurse and healthcare assistant (HCA) had an annual appraisal. The appraisal rate amongst nurses, HCAs and non-clinical staff was 90%. All staff who had not undergone an appraisal due to absence had a date scheduled for this. We looked at an anonymised sample of appraisals and found them to be detailed, personalised and in line with the requirements of the unit. Each member of staff was assessed against their completion of the trust's ten mandatory training topics and was involved in setting their development objectives and planned goals for the next 12 months. In each case the senior member of staff completing the appraisal recorded constructive and supportive comments that focused on supporting the individual member of staff to achieve their goals.
- Following the reconfiguration of the progressive care unit (PCU) as a high dependency unit (HDU) and the subsequent merger with the intensive care unit (ICU), the trust had funded 23 nursing staff to undertake a post registration qualification in critical care nursing. As a result 43% of nurses had completed this award. This did not meet the 50% minimum recommended by the Royal College of Nursing (RCN) but the unit was due to achieve a 51% completion rate by April 2017. All shift coordinators and practice educators had achieved this award, which met the requirements of the RCN and the ICS core standards for intensive care medicine.
- There was a lack of consistent oversight for nurse education and professional and clinical development. Nursing staff often completed training on an unpaid

basis during their personal time off. Three members of staff told us this had raised this as a concern with the senior team and had been threatened with disciplinary action as a result.

- Four nurses we spoke with were not clear about how their clinical competency was assessed by the senior team and felt there were no systems in place to provide constructive feedback on their performance. One member of staff said, "The matron told me I was incompetent because I did not have the ICU course but another senior nurse assigned me to be a 'floater' on the shift, which carries a lot of clinical responsibility. I asked for some help in understanding this but [the senior team] could not explain it." Three other nurses said they felt their clinical competencies were well managed by their mentors and they felt supported and happy with the level of training.
- The CCOT team provided study days on intravenous care and on-going competency assessments on tracheostomy care and the use of the national early warning scores (NEWS) system.
- A new practice development nurse (PDN) had been appointed shortly before our inspection and was supported by two practice educators. Although a member of staff had previously filled this post, new education and training plans were yet to be implemented. To address a number of staff resignations, 14 new staff nurses had been recruited. The combination of these two events, together with the transfer of the PCU into the critical care complex (CCC) meant there was a relatively inexperienced nursing team in place. Some experienced members of clinical staff told us this placed "exceptional pressure" on the unit. One member of staff said, "A lot of more junior nurses have to act up during shifts to supervise the very new staff. They often don't have the qualities or a strong enough personality to lead a team in this environment. I don't feel confident on shift because the [shift leaders] are not always knowledgeable or experienced." The PDN had implemented a plan to ensure staff were trained appropriately whilst receiving supervision and support. This included providing daily learning objectives, assessing practical competencies throughout their first year of service and reflective exercises for nurses to identify their own learning needs.

Critical care

- Opportunities were available for HCAs to undertake an assistant practitioner course. This enabled them to develop clinical competencies and to provide a greater level of support to patients and nurses, including ventilator and haemodialysis technical support.
- Staff in specialist roles in the hospital were able to provide dedicated training and support to critical care nurses. This included recent drop-in sessions for staff with a specialist nurse in organ donation who provided the information given during the sessions to all unit staff afterwards.
- The root cause analyses of serious incidents had identified training needs for staff. This included training on the escalation of deteriorating patients and the care of patients with a learning disability. There was limited evidence this had been provided.
- Consultants used handovers to facilitate teaching and learning sessions with trainee doctors, nurses and CCOT. For example, during one handover a clinical fellow presented a teaching session on the use of phosphate in ICU.
- Doctors attended a weekly journal club to share their findings from research and audits. Staff told us this was a useful way to learn together and to ensure practice in critical care represented the latest available best practice and findings from novel treatment projects.
- Regular study days were held by clinical staff. These were well attended by a cross-section of staff, including all grades of the medical and nursing teams, dietitians, physiotherapists and other members of MDT teams. A member of staff often presented a clinical case study as part of the study days and past cases included acute atrial fibrillation, meningitis and hypertension. All of the staff we asked about this programme told us it was highly beneficial to their professional development.
- CCOT provided bedside teaching and learning support to nurses to develop skills in caring for deteriorating patients and those with complex conditions and in conducting physical examinations. This team also audited staff knowledge and practice in the safe use of peripherally inserted central catheters (PICC) and conducted knowledge assessments on nasopharyngeal airway suction. All new members of staff in critical care undertook PICC training and the CCOT team was preparing a new competency check document.
- A team of 10 senior nurses provided a CCOT service 24-hours, seven days a week. This team visited patients and staff on wards to assist in the care of patients with a tracheostomy and other conditions where ward staff needed assistance. The CCOT team also responded to patients with deteriorating conditions and worked with physiotherapists and the speech and language therapy team to implement weaning plans.
- A dietitian had recently been appointed to work in the CCC on a 0.5 whole time equivalent (WTE) basis. This was below the 0.85WTE – 1.7WTE dietitian cover range established by the trust as the safe level needed. A business case was in progress to secure additional funding for greater dietitian cover. The dietitian attended handovers three days each week, joined ward rounds two days each week and ensured every patient received a nutrition and hydration screening on admission.
- MDT staff were involved in all aspects of clinical care and governance operations in critical care. This included pharmacy, dietitian and physiotherapist presence during medical handovers and ward rounds as well as involvement in incident and bed management meetings.
- We spoke with a consultant physician on the acute medical unit about their relationship with the CCC. They told us relationships between clinicians were very positive and ensured patients received the most appropriate MDT care. They said, “Critical care doctors are very helpful and approachable and the trainee medical doctors feel confident approaching them with referrals.”
- Two full time pharmacists were dedicated to the unit and provided cover Monday to Friday from 8am to 5pm. Outside of these hours, staff had access to an on-call pharmacist.
- Two full time physiotherapists worked in the unit and provided patients with 45 minutes of rehabilitation time, in line with ICS guidance. Patients did not have access to occupational therapists.
- A microbiology consultant conducted a weekly ward round.
- A consultant, the matron and a senior nurse had started a follow-up clinic in the month before our inspection. It was planned this would take place on a monthly basis but due to a lack of capacity in the therapies teams, there was no provision to ensure a physiotherapist was

Multidisciplinary working

Critical care

present at the clinic. This meant the service did not meet the requirements of NICE clinical guidance 83, which provides best practice guidance on rehabilitation after critical illness.

- During our inspection we asked 11 nurses and HCAs about 'link' or 'champion' roles in the unit. These roles are usually assigned to staff with a special interest in an area of clinical care or operational practice and enable them to complete additional training to provide dedicated support to colleagues on the unit. Nine members of staff said they were not aware of any link roles in the unit. We spoke with the hospital's infection control lead nurse who told us an infection prevention and control link nurse was in post in the CCC and all staff should be aware of their role. After our inspection the trust provided a list of 24 distinct nurse and HCA link roles including dementia and bowel management and staff welfare such as social events.
- Senior staff held a bi-monthly MDT meeting that included physiotherapy, pharmacy, ward clerks and clinical staff. The team used this time to highlight areas of need in patient care and staff practice. For example, in one meeting a physiotherapist identified a need for more detailed nurse training in moving and handling patients. As a result nurses received prone positioning and mobilising training specific to the needs of CCC patients.

Seven-day services

- The consultant service was provided 24-hours, seven days a week in line with FICM and ICS guidance. Consultants were typically present in the CCC until 10pm and were available on-call within 30 minutes overnight. A clinician with advanced airway skills was available in the hospital at all times.
- Out of hours urgent physiotherapy support was available for cardiology work between the hours of 4.30pm and 8.30am, Monday to Friday. There was no weekend cover available for therapies due to short staffing.

Access to information

- Staff had access to previous discharge summaries on the electronic records system when patients were admitted. However, this system did not include all areas of the hospital and staff offered relied on paper notes to understand a patient's medical history.

- Discharge summaries had recently been the focus of a drive to improve documentation. This included discharge summaries to wards and to GPs when a patient left the hospital.

Consent and Mental Capacity Act

- The cognitive assessment method for ICU (CAMICU) had been introduced to the unit in September 2016 and an ICU consultant was preparing a new delirium policy.
- Staff demonstrated inconsistent knowledge of the Deprivation of Liberty Safeguards (DoLS). One senior clinician did not know what this was or when it should be used but a trainee doctor was able to discuss it in detail.
- There was limited information available to staff on the unit for quick reference in relation to consent and mental capacity. Nurses we spoke with had a varying understanding of this and said they usually deferred to doctors when they had a concern about mental capacity.

Are critical care services caring?

Good



We rated caring as good because:

- Staff demonstrated a clear understanding of the importance of privacy and dignity and were proactive in maintaining this for patients and their relatives.
- The matron conducted a monthly patients' and family members' feedback survey. Feedback from this in relation to staff and communication was variable but in every month for which data were available, positive comments were received about the caring and kind nature of staff.
- Some patients and relatives said they felt involved in their care and treatment and understand what was happening. Other people told us communication was inconsistent and said they would like more involvement from staff.
- Bereavement, emotional support and chaplaincy services were available to patients and relatives.

However:

- There was a lack of evidence feedback from the patients and family survey was used to drive improvements in the service through better staff supervision and training.

Critical care

This included several consecutive months where negative feedback had been received about the gruff or unfriendly approach of a minority of staff. Although this was shared openly with everyone who visited the unit, there was no process in place to ensure it was followed up.

- Interaction between staff and patients was of variable quality. Most staff demonstrated compassion and made sure patients understood what was being said. This was particularly the case during a medical ward round. However, we also observed one nurse speak with patients very formally and with no warmth and we observed a doctor talking on their mobile phone about another patient whilst at a bed side. Patient records indicated a variable approach to documenting interactions with relatives.

Compassionate care

- Staff in the unit ensured privacy and dignity in their interactions with patients and their relatives, other services and in the operation of the unit. For example, the patient information boards on display at nurse stations included only initials and no personal information that could be used to identify them. Staff gently assisted relatives to private areas when they were upset and disorientated and ensured they had access to food and drink.
- Where police officers were required to maintain supervision of patients in the unit, clinical staff facilitated this in a way that maintained people's dignity and did not impact their care.
- In all of our observations staff demonstrated kindness and compassion when speaking with patients and their relatives.
- The matron managed a patient and family feedback survey, which was given to people on discharge from the unit or posted to their home address. Feedback from this survey was anonymised and posted on a display board regardless of whether it was positive or negative. Staff said this helped them to make sure their communication with people was transparent and made sure they could demonstrate how they worked to improve the unit based on feedback. Patients and relatives gave variable feedback on their experiences in the unit between January 2016 and June 2016. For example, two comments were made in May 2016 in

which respondents stated they felt staff could be more caring. However in April 2016, respondents commented on the kindness of staff and on how they felt their needs had been met.

- We spoke with six members of staff about the negative comments received from the patient and family feedback survey. All of the staff said they felt there was a lack of communication training which meant some individuals could sound aggressive and uncaring when this was not their intent.
- We asked five patients and six relatives about the care they received and received variable comments. One patient said, "Some of the nurses are quite gruff and abrasive. You get to know which [nurses] you can speak to who will be friendly." Another patient said, "Language is a problem, some of the staff don't have good English language skills and I get worried they don't understand what I'm asking." We asked human resources staff about English language support for staff and were told there was no provision in the trust for this.

Understanding and involvement of patients and those close to them

- Staff at all levels demonstrated an understanding of the anxiety the unique nature of the environment could cause to patients and their relatives. A healthcare assistant told us they found showing relatives to the quiet room and offering a drink was a successful technique to help people to acclimatise to the unit. Nurses helped to reduce fear and uncertainty by explaining to patients and their relatives what items of equipment were for and what the various noises and lights were used for.
- We observed a variable approach to interaction with patients from staff. For example, during a handover staff spoke with a patient kindly but used jargon in their communication, which confused the patient. During another observation we noted a member of staff was very formal when talking to a patient and did not demonstrate obvious kindness or warmth.
- Doctors demonstrated they knew patients well during ward rounds we observed and involved them in discussions and decision-making about their treatment. However, during one ward round the consultant was interrupted several times by their mobile phone and had conversations at a patient's bedside that should have been conducted privately.

Critical care

- Patients and relatives gave us variable feedback in relation to how involved they felt in their care. One patient said, “I hardly saw the nurse yesterday. They were so busy I just had my buzzer to press if I wanted anything.” Another patient said, “The doctor comes in for a chat but I don’t know what my plan of care is and they haven’t mentioned discharge to me.” A relative said they felt they had been “pushed” into an uncomfortable decision by a consultant. They said, “I didn’t feel ready to make a decision about [family member] and I wanted much more information than they were willing to share.” Another relative said, “I’m getting frustrated with the lack of joined-up working here. Yesterday a doctor told [another relative] something that contradicts what I have been told today about [patient’s care plan]. Then a little while ago a nurse told me something again, it seems difficult to get accurate information.” One relative said, “I’ve been kept really well informed. I know what the plan is for [the patient] and what the discharge procedure is. The staff have involved us every step of the way and I feel very fortunate about that.”
- There was a clear drive to improve communication between staff teams, patients and relatives. This included communication training for staff and a meeting with a previous patient.
- Patients had access to culturally-appropriate food and menus had been translated into commonly spoken languages. A pictorial menu was also available to help patients with limited communication.
- A consultant was leading a project to improve care for patients living with dementia. This included study sessions for staff and better resources on the unit. This was in process at the time of our inspection and very few of the clinical staff we spoke with had a good understanding of dementia.
- Discharge delays were significantly lower than the national average and the majority of patients were discharged within four hours of the decision being made.
- Medical staff adhered to national best practice guidance during admissions processes.

Emotional support

- A bereavement office was available on site and was open Monday to Friday. A multi-faith chaplaincy service was available 24-hours, seven days a week for emotional and spiritual support.
- One relative commented in survey feedback that a nurse had been respectful of their religious needs and as a result they felt supported and better able to cope.
- We asked 10 patients and relatives about emotional support. None of the patients had been offered this and said they would not know how to access it. One relative said, “No, I haven’t been asked how I’m doing or how I’m feeling. I come in every day as well, I do think the culture here is quite stand-offish, it’d be nice to ask how I’m doing when [staff] see me.” One patient said, “I don’t think I need emotional support at the moment but no-one has asked me about it.”

Are critical care services responsive?

Good 

We rated responsive as good because:

However:

- Staff demonstrated a low level of knowledge of providing care to patients with a learning disability. Although the hospital had a learning disability lead in post, none of the nurses we spoke with knew who this was.
- There were limited facilities for relatives on the unit but a new quiet room was being furnished, which would include drink and snack-making facilities.
- The rate of out of hours discharges to a ward was significantly higher than the national average, representing 14% of patients compared to the national average of 4%.
- A complaints procedure was in place and was readily available to patients, relatives and visitors. Three formal complaints were received in the 12 months prior to our inspection but there was limited evidence the complaints led to significant change, particularly in relation to the communication and attitude of some members of staff.

Service planning and delivery to meet the needs of local people

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- Guidance and information for carers was available on the unit, including a carers passport scheme. The carers passport scheme had been due for review in July 2015 and there were no documented updates to the scheme more recently than this.
- The senior team had a demonstrable focus on improving communication between staff groups and with patients and relatives. This was in response to feedback from patients and relatives who felt their needs had not been met in full due to poor communication. To ensure future service planning included communication as a priority, the matron invited back a previous patient to discuss their experiences in the unit. This meeting was well attended by a range of unit staff and, with a communication development day for the multidisciplinary team, provided valuable insight for staff into how they could improve communication with patients.
- Staff could refer patients to one of two regional home ventilation services for treatment after they were discharged.
- A specialist nurse in organ donation was available in the trust and provided specialised support to critical care staff. Three organ donations were successfully completed between April 2015 and March 2016.
- The age suitability of the nuclear medicine equipment was a concern. It had been on the risk register since 2009.
- Out of the total appointments made at the hospital, 20% had been cancelled by either the hospital or by the patients. The data did not break it down further into the reasons for cancellation.

Meeting people's individual needs

- There was limited evidence the unit was equipped to provide consistent and reliable support to patients with dementia. A consultant had started work to improve this and as an initial step had prepared a resource pack for staff to help them understand how to communicate effectively with patients with dementia. This was readily accessible and staff said they had attended briefing talks with the consultant on this. In addition, a dementia information board was on display in the unit that included advice on supporting patients with the condition. A dementia resource folder contained recent research on treating the condition and a guide on communication for staff and relatives. However, not all staff were offered the opportunity to complete dementia training and very few of the staff we spoke with knew who to contact for specialist advice or guidance.
- Staff were not always able to respond to patients' individual needs in a timely manner. For example, the family of one patient cared for in a side room had brought a TV set in to help reduce their feelings of boredom and isolation. To ensure the item met hospital electrical safety requirements, it needed to undergo a portable appliance testing check. This had not taken place in the three days since the TV set was brought in, which the patient was frustrated about.
- A dietitian dedicated to the unit worked with patients and their relatives to meet cultural food needs, including providing kosher, halal and vegan food. Printed menus had been translated into over 15 commonly-spoken languages, including Turkish, French and Polish, which were the most common languages other than English in the local area. Menus were also available in picture format and two relatives told us they had proven very useful in helping their family members choose their own meals.
- Interpreters and translators were available if booked in advance. Staff told us they sometimes had to rely on relatives translating for them and have been able to communicate with patients by using online translation software. During our inspection a doctor secured a French clinical translator to accompany them during a ward round for one patient to enable they were involved in their treatment plan.
- There were limited resources on the unit to help staff communicate with patients with a learning disability. A nurse told us they had received communication training that helped them but they would rely on friends or family of a patient to help communicate. None of the staff we asked knew if there was a learning disability lead in the hospital although there was evidence study days had been offered in the previous six months to all staff on caring for patients with a learning disability.
- Staff had prepared a printed information leaflet for relatives visiting the unit. This included an overview of the procedures and equipment that were common on the unit and information on other hospital services as well as who to approach for help or advice.
- A palliative care team were available on-call for staff and their contact details were readily available.

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- A quiet room was available on the unit although there were no facilities for people to make their own drinks. A separate, better equipped room was being furnished.

Access and flow

- Between June 2015 and February 2016, bed occupancy was between 60% and 80% of capacity, which was below the national average. From March 2016 to May 2016, bed occupancy was above the national average, including four weeks when the unit operated at 100% of capacity.
- Between April 2015 and March 2016, 14% of patients experienced a discharge to a ward between 10pm and 7am. This is described as an 'out of hours discharge' and can lead to additional clinical complications for patients. This rate was significantly higher than the England average of 4%. During the same period one patient was transferred out of the unit for non-clinical reasons. This represented 0.1% of the total patients in the unit and was better than the England average of 0.7%.
- The average length of time patients spent in critical care was 70 hours between April 2015 and March 2016, which was slightly longer than the national average of 66 hours.
- Discharge delays were significantly lower than the national average. Between April 2015 and March 2016, 77% of patients were discharged within four hours of the decision being made compared to a national average of 36%. In addition, 20% of patients experienced a discharge delay of between four and 24 hours, compared to the national average of 43% and 3% of patients experienced a discharge delay of over 24 hours, compared to 21% nationally.
- Two dedicated ward clerks provided support to clinical staff in the preparation of documentation for patient discharge.
- During medical handovers we saw staff adhere to a national gold standard of patient admission and management planning. This included identifying the most appropriate beds for patients based on their needs, including known infection risk and transferring low-acuity patients from the intensive care unit to the high dependency unit to ensure new patients were treated appropriately.
- Medical staff said they preferred to discharge patients to wards on a Friday to give them time to settle in when wards were typically better staffed. However, this meant the lack of discharges on a weekend resulted in patients remaining in critical care when they could be more appropriately cared for elsewhere. The nurse in charge of each unit liaised with the site practitioner or bed manager to expedite discharges but this process was not always effective due to a lack of capacity in medical inpatient wards. The discharge lounge was sometimes used when there was a lack of capacity across the hospital but this service was not available at weekends.
- Between June 2015 and August 2016, four incident reports related to insufficient discharge from critical care to a ward. In two cases this related to missing or insufficient discharge summaries. There was no evidence the investigations of the incidents were robust or fit for purpose. One incident investigation had no outcome or action plan and another, dated July 2016, included only a note from the matron for the clinical lead to look into the situation further. This demonstrated a significant lack of oversight and ownership from the senior team in investigating incidents relating to discharge documentation.
- Staff used a daily multidisciplinary meeting to monitor hospital bed capacity that had an impact on critical care. This included a review of out of hours discharges, delayed discharges, delayed admissions and patients discharged home directly from critical care. The meeting facilitated planning between critical care doctors, nurses, bed managers and the hospital risk lead to minimise the risk caused by poor flow through the hospital. Staff used the meetings to identify where the areas of poor flow were and consider how this could be improved.
- The audit team planned three audits for 2016/17 focused on benchmarking patient discharge and readmission rates against Faculty of Intensive Care Medicine and Intensive Care Society standards as a strategy to improve processes that impacted access and flow.

Learning from complaints and concerns

- Between July 2015 and July 2016, critical care received three formal complaints. Two complaints were in relation to staff attitude and communication and one complaint was in relation to personal property. The clinical lead and matron investigated all three complaints appropriately and as a result one complaint was upheld and another was partially upheld. Where staff attitude had found to need improvement, the

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matron had recorded support and extra training had been provided. However, there was limited evidence this had been effective. One of the complaints relating to poor staff attitude was received in March 2016.

- In July 2016 two relatives noted in a survey they felt some staff were unfriendly and during our inspection we received feedback from patients and relatives that not all staff were kind and compassionate. This meant there was not a robust or proactive system in place to ensure all staff responded to patients and their relatives in an appropriate manner.

Are critical care services well-led?

Requires improvement



We rated well led as requires improvement because:

- The service maintained a risk register but this was not always supported by robust, manageable action plans.
- There was little evidence staff had been involved in significant changes to the configuration of the service or that the senior team facilitated structured methods of staff engagement. Changes to the leadership structure had demonstrably impacted staff but the lack of governance around this meant it had failed to drive consistently positive change in the unit.
- Nurse vacancies had been significantly reduced in the previous 12 months. This was achieved in part through recruiting less experienced junior nurses. A new practice development nurse was planning a skill mix review to ensure staff received the training and support they needed. However, sustained high levels of sickness and turnover amongst the nursing team jeopardised this.
- Although public engagement was apparent through a monthly survey, there was limited evidence feedback was used to implement changes and improvement.
- The nursing team was defined by high levels of sickness and a fractured working culture. Some nurses and healthcare assistants told us they felt supported and motivated. However, the majority of staff from this team we spoke with described a culture of punitive behaviour from senior staff, a work environment in which racist and homophobic behaviour went unchallenged and a lack of transparency in recruitment and selection. We were contacted by a significant number of staff on the condition of anonymity around this. The trust

acknowledged they needed to address concerns around poor levels of support for equality and diversity and demonstrated a plan to address the most serious concerns imminently. This included an improved equality and diversity staff support structure and an independent consultation of the critical care staff team.

- Staff discussed their concerns about the lack of confidentiality between senior nurses, managers and the human resources department. This included specific instances where they felt highly personal information had been shared without their consent and result in a working culture in which some staff told us they would not use the confidential 'whistleblowing' escalation policy in the trust. This represented a significant risk to the protection of vulnerable patients because it meant some staff would be afraid to raise concerns about substandard treatment for fear of reprisals.

However:

- The critical care delivery group had a robust plan to improve service delivery at all levels of the unit, which complemented the strategy of the clinical business unit.
- Engagement and leadership within the medical team was highly regarded and doctors we spoke with told us about a supportive environment in which they felt able to develop clinically.
- The matron and a healthcare assistant had organised events to celebrate diversity amongst the staff team and to improve working relations. Another healthcare assistant was the link for staff social events, which included the unit's first annual ball.
- Although the strategy for the clinical business unit of which critical care was a part had little detail for this specific area, some staff had contributed to a philosophy for the unit to provide patients and relatives with a minimum level of service they could expect.

Vision and strategy for this service

- The senior team had significantly reduced the nurse vacancy rate by filling 23 vacant posts since July 2015. The immediate strategy for this team was to improve nurse retention and ensure new nurses received the training and professional development needed to increase their skill set in critical care. The matron was also aware of a need to improve the quality of mentorship for new nurses in the unit. Although there was a clear drive from the senior team to achieve this, there was limited evidence of a robust and structured

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plan. In addition, sustained high rates of sickness, at a monthly average of 7% of nurses between July 2015 and July 2016, and significant evidence of poor working relationships meant it was not clear how a reliable, highly qualified team would be achieved.

- The critical care delivery group established their vision to modernise the service through 20 distinct group objectives that aimed to bring the unit in line with national best practice guidance and improve outcomes for patients. The vision formed part of the group's draft terms of reference, which were awaiting ratification during our inspection.
- The clinical business unit had a business plan in place for 2016/17 that focused on streamlining the efficient running of services through good relationships with the clinical commissioning groups and support for nursing staff to complete training and appraisals. The plan aimed for the critical care follow-up clinic to be fully operational and for the service to improve pain management. The critical care complex had a specific strategy for 2015 – 2017. Part of the strategy had already been achieved, through the reconfiguration of the unit to incorporate the intensive care unit (ICU) and the high dependency unit (HDU). Other areas included a focus on nurse staffing, including staffing levels and clinical competencies.

Governance, risk management and quality measurement

- The critical care complex (CCC), comprising of an ICU and an HDU, was part of clinical business unit four (CBU4) and was led by a clinical director, deputy clinical director, managing director and head of nursing. A clinical lead, matron and lead nurse for critical care outreach formed the clinical service leadership team.
- CBU4 maintained a risk register for all clinical services and five risks were attributed to the CCC. Two of the risks had action plans in place and were due for review. One risk related to the lack of a safety hypodermic needle in central or arterial line packs and had been due for review in September 2016. Another risk related to the number of overnight ward transfers, which was due for review in October 2016. The action plan for this risk related only to daily review in bed meetings and did not provide a guided structure for staff to follow. One risk related to the reconfiguration of the progressive care unit (PCU) to an HDU, subsequent merger with ICU and the need for improved staff competence as a result. This risk cited staffing levels as an ongoing concern and was due to be reviewed in August 2016 but did not include a coherent action plan.
- A weekly critical care 'cobra' meeting was used to monitor incidents and enabled staff to provide detailed input into monthly risk and governance meetings.
- Healthcare providers have 'whistleblowing' policies to enable staff to raise concerns about safe practice confidentially, without fear of reprisal or intimidation. However, staff we spoke with were apprehensive about this to an extent that would prevent them from raising safety concerns with senior trust staff. One senior nurse said, "I would not raise any problems here about other staff. This is an environment of favouritism and if [senior staff] think you're causing trouble they make sure you are overlooked for development or promotion. There is no transparency in the way the senior team works and I have doubts about confidentiality here." Another member of staff said, "No, I would never raise any concerns about staff behaviour or conduct, I'd be very afraid of losing my job. This isn't a supportive place to talk about problems or worries." One member of staff said they had previously used a procedure that enables staff to contact human resources (HR) in confidence when they were worried about the conduct of a senior member of staff on the unit. They said, "HR told the member of staff I had raised concerns about. I was totally undermined and felt very uncomfortable here. The whole thing was handled badly and I would never raise a worry again, no matter what happened." We spoke with the director of HR and the director of nursing about this. They told us HR had policies in place to ensure staff confidentiality and said this would only be broken if there was an immediate safety risk to patients or staff.
- Risks associated with short staffing had been highlighted by senior staff following relatively high sickness absence rates amongst nurses. We spoke with HR advisors about this who said this was only monitored if trends in sickness were noticed, at which point the occupational health team would become involved. There was not a coherent understanding of the concerns raised by staff in critical care and it was not clear that HR support services were appropriate to manage the challenges critical care staff talked about.

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For example, an HR advisor was available on the unit one day per week. However this was primarily to discuss staffing levels with the matron and was not immediately available for staff to receive support.

- A critical care delivery group monitored governance in the unit, including oversight of delayed and overnight discharges. This working group adhered to a 'better safer faster' principle of governance and aimed to improve quality performance.
- A bi-monthly audit and governance meeting took place that included briefing of information from the critical care network.
- The last information governance audit had taken place in December 2015 and assessed the unit against seven key criteria. The audit noted staff had an appropriate system in place to dispose of confidential notes and that fax systems were secure. The audit noted that some loose filing was in evidence but did note if this was in accordance with information governance policies. There were no outcomes or recommendations from the audit.

Leadership of service

- There had been significant changes to the leadership and structure of the CCC during the 18 months prior to our inspection. This included the appointment of a new matron who, along with the clinical lead, led the CCC. Staff we spoke with gave us variable feedback on leadership. One member of staff said, "The change of the PCU into an HDU was handled very badly. There was no consultation or information given to us. I felt very aggrieved by that, I think we should be involved in things that change our job so much." Another member of staff said, "The leadership is there if [senior staff] happen to like you. I don't think it's fair or given to us equally." Other staff were more positive. For example one person said, "There was a lot of hostility when the units combined but I think that is behind us now. The matron is very clearly working hard to make sure the unit is able to care for our patients safely."
- We asked the trust for a business or change management plan related to the combination of the two units and the related change in expectations of staff. In response the trust supplied a letter the matron had used to contact staff about the change that included a merger plan. This included a non-negotiable change of shift working patterns and responsibilities. Although the letter offered staff the opportunity to

provide feedback on the change, it was clear decisions regarding the merger had been made and there would be no formal consultation process or informal channels through which staff could discuss their concerns.

- One week before our inspection a new deputy matron post had been created. Although staff had not yet been included in the plans for this role, the member of staff was an experienced critical care nurse and it was planned they would provide a substantive link between the matron and staff teams with a focus on clinical leadership.

Culture within the service

- During our inspection a significant number of staff contacted us on the condition of anonymity to raise concerns about bullying, harassment and victimisation in the unit. They told us they felt the unit had a racist and homophobic culture and gave examples of how they felt victimised based on these grounds. One member of staff said, "I have heard open and offensive homophobic comments from staff on the unit about me. It is very distressing and I've been left to defend myself." We spoke with the director of HR and the head of nursing about this. An independent consultation into staffing in critical care had been organised and we were told a new equality and diversity lead was in the process of starting a new trust-wide drive to improve working relationships and eliminate bullying and harassment. HR staff also told us all staff had access to the trust's bullying and harassment policy but none of the critical care staff we asked about this were aware of it. There was very limited evidence HR advisors were equipped to effectively support staff who felt victimised based on their identity. HR staff told us all employees received conflict management training, which formed part of the mandatory training package. Records indicated 76% of staff in critical care had up to date conflict management training but none of the staff we spoke with were able to talk about this.
- The matron and a healthcare assistant (HCA) had organised two 'diversity days' in the unit to try and improve team cohesion and to help staff from different cultures to communicate with each other more effectively. This provided an opportunity for staff to meet each other without the pressures of being on shift and caring for patients. In addition the matron had displayed the flags of the countries of origin represented amongst the team at the entrance to the unit. Staff we

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spoke with were proud of this and said it had gone some way to improving relationships as individuals began to respect the value of such diversity. One member of staff said, “We feel less divided after the days, I think they worked well. The chief executive came to one of them, I think that was a big help.”

- Equality and diversity drives in the hospital were almost entirely focused on race and there was no structured support for lesbian, gay, bisexual or transgender staff. Staff we spoke with said they felt the senior staff in the unit lacked an understanding of their responsibilities under the Equality Act (2010). We spoke with the director of HR and the director of nursing about this. They told us an independent consultant had been appointed who would spend one week in the unit talking with staff to implement a plan to ensure everyone was treated fairly and was not subject to harassment.
- We spoke with 11 members of staff about the working culture in the unit. They described a culturally diverse team and said this could be a substantial asset to the unit but told us there were problems with team cohesion due to “competing beliefs and tribalism.” For instance, six members of staff said they felt some individuals worked in a clique, which meant other staff were isolated if they were on the same shift. This meant some staff did not feel confident to raise concerns during a shift, which affected their morale and ability to communicate effectively. One member of staff said, “Many of my colleagues will speak to each other in their own language, which no-one else understands. It’s intimidating and the senior staff should stop them but they don’t.” Another member of staff said, “The best thing about working here is [my team]. The team leaders are so supportive and [a consultant] is very good if we need emotional support.”
- Some staff described an unfriendly, unsupportive working culture. One member of staff said their manager never said hello, smiled or made time to speak to them. They said, “It’s very demoralising to be ignored every day. They started saying hello to me when this inspection was announced; I know it’s not genuine.”
- There was inconsistent evidence of understanding of the duty of candour amongst staff. One senior clinician said they did not know what this was but nurses said they deferred to doctors in such cases. Overall nurses had a good understanding of the need for transparency and open communication.

Public engagement

- A patient, relative and visitor information board was on display at the entrance to the unit. This included details of how the unit had responded to feedback. For example, a new quiet lounge was being furnished that would include facilities to make food and drinks and senior staff were committed to improving communication through staff study days and multidisciplinary team training days.
- Following feedback from a previous patient regarding communication between clinical teams, the matron invited the person back to spend time speaking with staff about their experiences. This helped to begin a programme of improvement in communication training.

Staff engagement

- Nine members of staff told us they felt opportunities for development and progression were offered on the basis of favouritism. They said they did not feel a transparent system of merit and professional competence was used when decisions were made about promotion. One member of staff said, “The transparency is not there when new people are recruited or someone is promoted. It’s very discouraging to see someone who did not meet the job criteria get promoted over you when you get no feedback or advice from the senior [staff].” Staff also spoke to us about a lack of flexibility in the staffing of the service to help them achieve a healthy work/life balance.
- The matron had introduced a “have your say” slot during morning nurse handovers. This provided each member of staff with the opportunity to ask questions or raise concerns about anything in the unit. We asked nine members of staff about this. Three individuals told us the opportunity was a positive one and had improved communication in the unit. Five members of staff told us they were fearful of raising concerns because of the risk of reprisals from the matron. One individual said, “I used this [system] once and voiced my concern over something that happened that I thought wasn’t safe. I regretted it straightaway; the matron has treated me differently ever since. I feel like I’m being watched and every time I’ve asked for something since then the answer is ‘no.’”
- The senior team had arranged a number of social events as part of a strategy to engage staff more broadly and reduce a period of friction. This included an annual ball,

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a farewell party and a celebratory long-service party.

Staff told us this was the first time many staff had the chance to get to know each other and the events helped to improve working relationships and levels of respect.

- A trial had taken place in June 2016 to enable nurses to organise their own working rota. This was in response to a period of instability in which nurses had expressed concern they could not secure days off or their preferred shifts. Although notices regarding the trial remained on display on the unit, none of the staff we spoke with could tell us if this had been a success or if the outcome had resulted in greater stability for them.
- HCA team meetings had recently been introduced and staff spoke positively about them.

Innovation, improvement and sustainability

- Several staff spoke with us about the sustainability of the service, following the resignation of a large number of nurses. One nurse said, “They [staff] left because of the pressure and constant stress and the lack of support from senior staff.” The senior team demonstrated a clear understanding of the risks associated with staff attrition but there was limited evidence the system of exit interviews had been used effectively to improve nurse retention.
- HCAs we spoke with said they felt there were few opportunities for progression or development and they were unclear how they would continue to contribute to the service without more support and investment for training. Six nurses we spoke with said they felt

development opportunities were restricted and this had an impact on the sustainability and development of the service. For example, one nurse had been unsuccessful in applying for the ICU course but said the lack of transparency and support around this meant they were not able to consider their next step in professional development. They told us, “I was deemed ‘not clinically able’ to complete the ICU course but they didn’t tell me what that meant. I asked for an assessment of my clinical competence because I was worried after this but [senior staff] said they didn’t have time and because the PDN had left there was no-one who could help.” After our inspection we asked the trust about the selection procedure for staff applying for the ICU course. Due to the resignation of a practice development nurse, we were told the selection process was not rigidly followed during the most recent intake. Although there robust and appropriate acceptance criteria were place, the policy did not include structured feedback or support for unsuccessful applicants.

- The critical care outreach team were leading a project to introduce treatment escalation plans across the hospital. This would enable medical staff to make collaborative and timely decisions about on-going care using a more efficient method than that currently in place.
- The unit was part of the national multi-centre PRISM trial, which aimed to research effective treatment for patients with Paget’s disease.

Maternity and gynaecology

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

Information about the service

The maternity and outpatient gynaecology services at North Middlesex University Hospital NHS Trust (NMUH) are part of clinical business unit 5 (CBU5) which provides women's health and children's services. CBU 4 is responsible for surgical services and manages gynaecology in-patient services. The trust's maternity services are available across hospital and community settings.

Between January 2015 and December 2015, 5,146 babies were born at NMUH.

The maternity service at NMUH offers: a consultant-led delivery suite with 15 delivery rooms as well as three high dependency beds, two obstetric theatres with four recovery beds and a self-contained bereavement suite; an eight bed midwifery-led birth centre for low-risk women; an outpatient antenatal clinic; a six bed maternity day unit (MDU), a seven bed triage unit, including a four bed bay for induction of labour; 31 beds on the antenatal and postnatal inpatient wards and a maternity transfer lounge. Women can also choose to have a home birth supported by community midwives. Six teams of community midwives provide antenatal care, parent education classes, home births and postnatal care in children's centres, GP surgeries and women's own homes. The maternity services also include specialist provision, for example for women with diabetes.

The gynaecology service at NMUH offers: consultant-led inpatient care, outpatient care and emergency assessment facilities. Outpatient care includes colposcopy, hysteroscopy, recurrent miscarriage clinic, and

pre-operative assessment. There are designated services for suspected gynaecology cancers. A team of consultant gynaecologists receive support from registrars and junior doctors, specialist nurses, general nurses and healthcare assistants.

This report focuses on outpatient gynaecology and the pathway and care that in-patients receive; more detailed findings related to the in-patient gynaecology service are reported on in the surgery section of this report.

We visited all wards and departments relevant to the services. For the maternity services we spoke with 11 patients and 32 midwives and support workers. For the gynaecology services we spoke with 11 patients and 12 staff including managers, nurses of all grades, health care support workers and administrative staff. We also spoke with three managers and five medical staff who worked across both the maternity and gynaecology services.

We observed how people were being cared for and reviewed personal care or treatment records, including 10 sets of care notes of people using the maternity services, and 15 of people using the gynaecology services: eight outpatients and seven inpatients.

Maternity and gynaecology

Summary of findings

We rated this service as requires improvement because:

- We were not assured that the culture of the maternity services, staffing and capacity protected safe patient care.
- Systems, processes and standard operating procedures in maternity were not always reliable or appropriate to keep people safe.
- Staff were not confident their concerns were listened to or acted upon.
- We were not assured that staff were recording incidents correctly or that actions plans were put in place and monitored.
- Insufficient staffing levels meant midwives did not always provide one to one care during labour. 90% of patients received one to one care in labour in August 2016 and 84% in September 2016 which was not in line with national guidance.
- We were not assured that patients attending triage were attended to in a timely manner.
- We were not assured that patients were being cared for in the right place at the right time, by adequately qualified staff. This meant that patients may not receive timely care in the appropriate part of the service and be cared for by competent staff which put them at risk.
- 76% of registered midwives and 67% of obstetric consultants had attended practical obstetric multi-professional training (PROMPT).
- The trust was not meeting National Screening Committee targets for antenatal and newborn screening.
- National specifications for the prevention and control of infection were not always adhered to. There were no cleaning schedules or checklists available in any of the inpatient or outpatient areas we visited.
- During inspection there was no documentary evidence that any patients had a risk assessment to determine their individual risk of developing blood

clots, or that this was being monitored. However, the trust told us following the inspection that VTE assessments are mandatory fields on Maternity and compliance are reported on quarterly basis. the VTE performance in Maternity for the period of May to October 2016 was approximately 97%.

- Ambient temperatures of areas where medicines were stored were not monitored which meant that staff could not be sure that the manufacturers' instructions for storage were followed.
- We saw care and observation of a person receiving a blood transfusion in the gynaecology inpatient service was not in accordance with national or local guidance.
- Staff in maternity did not always observe the 'bare below the elbows' policy.
- The trust was offering group sessions for the first antenatal appointment known as the 'booking' appointment.
- Patients did not have a named midwife.
- We were not assured that the trust was implementing and reviewing audit recommendations.
- We were not assured that the trust was effectively monitoring the number of stillbirths. There was no action plan in place to address the stillbirth rate. New figures provided by the trust following the inspection showed that the stillbirth rate up to May 2016 was 4.4 per 1,000 births which was slightly lower and better than the national average of 4.7 per 1,000. The trust was not using customised growth charts to monitor fetal growth. We were not assured the service was monitoring and evaluating stillbirth rates to make improvements.
- Multidisciplinary team (MDT) working was not always effective in the maternity service.
- Patients' privacy and dignity were not always protected.
- Staff did not always address patients in an appropriate manner.

Maternity and gynaecology

- Patients, partners and relatives did not always feel involved in their care.
- There were long waiting times in triage. We saw that a patient waited for 50 minutes before being seen. Staff told us that patients can be in triage for up to seven hours in labour due to the lack of capacity or the willingness of the midwives on labour ward to accept women.
- Staff told us patients using the gynaecology service were generally seen promptly for treatment, however, this was not formally monitored.
- The leadership, governance and culture did not always support the delivery of high quality person centred care. Leaders did not have the essential experience, knowledge, capacity or capability to lead effectively.
- Staff had no clear vision and strategy of the maternity and gynaecology service. Staff could not tell us of future plans for the maternity service; however outpatient gynaecology staff described the relocation of their services to more suitable accommodation.
- The culture was not one of fairness, openness, transparency, honesty, challenge and candour. Staff reported bullying, harassment and discrimination amongst staff at all levels in the maternity unit. They said when they raised concerns they felt they were not treated with respect. The culture was defensive with poor collaboration between the staff working in different departments. High levels of conflict were reported to us.

However:

- Staff were trained to the appropriate level in safeguarding adults and children and were aware of their responsibilities to ensure patients and children were protected from abuse and avoidable harm.
 - The overall compliance with mandatory training for gynaecology training staff was 98.33% and midwifery staff was 90.47 % against the trust's 90% target.
- In gynaecology, there were systems in place to recognise and manage deteriorating patients. Appropriate triggers were in place to ensure patients who had deteriorated were treated according to their clinical needs.
 - During the reporting period there were no reported incidents of hospital acquired infections.
 - All clinical staff had access to a microbiologist and specialist infection prevention and control nurse when required.
 - Staff were observed in the correct use of personal protective equipment.
 - Staff had access to and used evidence-based guidelines to support the delivery of effective treatment and care.
 - Termination of pregnancy for fetal abnormality was offered in line with legal requirements and professional guidance.
 - Women we spoke with felt that their pain had been well managed. Epidurals were available over a 24-hour period.
 - Access to medical support was available seven days a week. Community midwives were on call 24 hours a day to facilitate the home-birth service.
 - The majority of women and those close to them were positive about the care and treatment they had received. Women were able to telephone Maternity Direct in working hours and triage out of hours for emotional support.
 - A bereavement midwife saw all patients who experienced pregnancy loss, including visits at home if required.
 - The trust had a chaplaincy team who were available to provide pastoral and religious support to patients and their families.
 - The maternity service was flexible and provided choice and continuity of care. Patients' individual needs and preferences were considered when planning and delivering services.

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- The individual care needs of women at each stage of their pregnancy were acknowledged and acted on as far as possible. There were arrangements in place to support patients with particular needs.
- Complaints about maternity and gynaecology services were initially managed and resolved locally. If complaints could not be resolved at ward level, they were investigated and responded to appropriately.
- Guidelines we reviewed were in date, reflected current NICE guidance and best practice, and included evidence of learning from SI reviews.
- There were good clinical working relationships between the medical staff.
- The trust participated in the North Central London Maternity Services Liaison Committee (MSLC), a specialist user involvement forum which brought together users and health professionals to develop women-centred maternity services.

Are maternity and gynaecology services safe?

Requires improvement 

We rated safe as requires improvement because:

- Systems, processes and standard operating procedures were not always reliable or appropriate to keep people safe.
- Staff were not confident their concerns were listened to or acted upon.
- We were not assured that incidents were being recorded correctly or that actions plans were put in place and monitored.
- Staffing levels meant there were insufficient midwives to always provide one to one care during labour which is not in line with national guidance.
- We were not assured that patients attending triage were attended to in a timely manner.
- We were not assured that patients were being cared for in the right place at the right time, by adequately qualified staff. This meant that patients may not receive timely care in the appropriate part of the service and be cared for by competent staff which put them at risk.
- The overall compliance with mandatory training for gynaecology training staff was 98.33% and midwifery staff was 90.47 %.
- 76% of registered midwives and 67% of obstetric consultants had attended PROMPT training.
- The trust was not meeting National Screening Committee targets for antenatal and newborn screening.
- National specifications for the prevention and control of infection were not always adhered to.
- There were no cleaning schedules or checklists available in any of the inpatient or outpatient areas we visited.

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- There was no documentary evidence that any patients had a risk assessment to determine their individual risk of developing blood clots, or that this was being monitored.
- Ambient temperatures of areas where medicines were stored were not monitored which meant that staff could not be sure that the manufacturers' instructions for storage were followed.
- We saw care and observation of a person receiving a blood transfusion in the gynaecology inpatient service was not in accordance with national or local guidance.
- Staff in maternity did not always observe the 'bare below the elbows' policy.

However:

- Staff were trained to the appropriate level in safeguarding adults and children and were aware of their responsibilities to ensure patients and children were protected from abuse and avoidable harm.
- In gynaecology, there were systems in place to recognise and manage deteriorating patients. Appropriate triggers were in place to ensure patients who had deteriorated were treated according to their clinical needs.
- During the reporting period there were no reported incidents of hospital acquired infections.
- All clinical staff had access to a microbiologist and specialist infection prevention and control nurse when required.
- Staff were observed in the correct use of personal protective equipment.

Incidents

- Staff told us that they were able to raise concerns and received feedback if they completed an incident form. However, not all staff were confident that their concerns were always listened to. Additionally, staff explained that they did not always have the time to report incidents. Staff in the maternity service told us they had been told by senior managers not to complete an incident form relating to staffing. We saw documentary

evidence that confirmed this was the case. There was no process in place to assure senior managers that risks were reported. For example, the birth register was not checked on a regular basis.

- Band seven midwives on labour ward told us they found it challenging to take ownership of incidents that took place on their shift.
- Escalation of risk was identified through an electronic incident reporting system. We saw that a trigger list based on the Royal College of Obstetricians and Gynaecologists (RCOG) recommendations was used in the maternity service to guide incident reporting. A trigger list was also in place in the gynaecology service. We saw that the trigger lists contained incidents that needed to be considered as Serious Incidents. Such incidents had to be escalated to the senior management team within 24 hours.
- All incidents were copied to the Head of Midwifery and Gynaecology Services (HoM) and were reviewed daily by the senior management team. Incidents classified as moderate or serious were reviewed at the Weekly Risk Review Meeting attended by the HoM, consultant lead for labour ward and risk, risk midwife, a consultant midwife and the midwifery matrons. If a root cause analysis (RCA) was required, it was delegated to a lead investigator. Discussions at the meetings were minuted. However, actions were not followed up in subsequent meetings to monitor progress. For example, we saw that 'the midwife to have feedback' or the 'midwife to be spoken to' were documented actions, but the details of the feedback and who would provide it were not recorded.
- Lessons learned from safety incidents were fed back to staff via a safety brief at shift handover, through discussion at the labour ward forum, via email, and in 'Burning Issues' a monthly clinical risk newsletter. However, there was confusion amongst all grades of staff we spoke with about the existence of the risk newsletter.
- We saw that 971 maternity and 133 gynaecology incidents were reported between May 2015 and June 2016. Analysis of the data demonstrated that in maternity four incidents were classified as level 5, four as level 4, 16 as level 3, 353 as level 2 and 593 as level 1.

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For gynaecology, three incidents were classified as level 3, 34 as level 2 and 96 as level 1; however, ten of the incidents reported for gynaecology were obstetric incidents.

- There was one never event in maternity in April 2016 which was a retained vaginal swab. We did not see evidence of this discussed at the Weekly Risk Review Meeting. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- We saw documentary evidence of 24 serious incidents between July 2015 and August 2016. 12 of 24 were reported to the NHS Strategic Executive Information System (STEIS) by the maternity services; the never event was not reported to STEIS. Of the 12 incidents reported to STEIS, two incidents concerned both the mother and the baby; three incidents concerned the mother only; and seven incidents concerned the baby only.
- There was an inquest where the Coroner had issued a Prevention of Future Death Notice (Regulation 28) to the Department of Health regarding the birth of a baby at NNUH. An action plan was followed to address issues raised by the incident which had been completed.
- We saw documentary evidence that there were 38 unexpected admissions to intensive care of patients using the maternity service between May 2015 and June 2016. Whether the patient was a mother or baby was not easily identifiable from the incident log; unexpected term (babies who were born at full term) admissions to the neonatal service was not recorded as a separate category on the incident log provided to us. However, unexpected term admissions were recorded on the Maternity Scorecard; no admissions were recorded for January 2016 to June 2016 and 4% recorded between July 2016 and August 2016. We were not assured the trust was consistently monitoring the number of term admissions to the neonatal unit.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety

incidents' and provide reasonable support to that person. We were told by managers that when necessary patients and those close to them were involved in reviews that they ensured that requirements under the duty of candour were met.

Safety Thermometer

- The trust provided us with information that demonstrated there had been no reported cases of *Clostridium difficile* (C.diff) infection and Methicillin-resistant *Staphylococcus aureus* (MRSA) in the maternity service or on S2, the inpatient ward where gynaecology patients were cared for.

Maternity

- The Maternity Safety Thermometer allows maternity teams to take a 'temperature check' on harm and records the proportion of mothers who have experienced harm free care, and also records the number of harm(s) associated with maternity care. The Maternity Safety Thermometer measures harm from perineal and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. It also records babies with an Apgar score of less than seven at five minutes and/or those who are admitted to a neonatal unit. The Apgar score is an evaluation of the condition of a newborn infant based on a rating of 0, 1, or 2 for each of the five characteristics of: colour, heart rate, response to stimulation of the sole of the foot, muscle tone, and respiration with 10 being an optimum score.
- The trust informed us following the inspection they have been collecting maternity safety thermometer data for seven months. However, this data have not been integrated into the maternity dashboard.
- On the maternity ward information displayed on the patient quality board demonstrated 100% compliance with hand hygiene; 100% compliance with MRSA screening; 92% breastfeeding initiation rate; and that 90% of patients would recommend the service to their friends and family.
- The patient quality board on the delivery suite demonstrated the caesarean section rate was 27%; the

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third or fourth degree tear rate was 1. %; 100% compliance with hand hygiene; 100% compliance with MRSA screening; and that 85% of patients would recommend the service to their friends and family.

Safety Thermometer - Gynaecology

- The NHS Patient Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This enabled measurement of the proportion of patients that were kept 'harm free' from pressure ulcers, falls, and urine infections (in patients with a catheter) and venous thromboembolism. Findings of the safety thermometer for S2, the surgical ward where gynaecology in-patients were treated, can be found in the surgery section of this report.

Cleanliness, infection control and hygiene

- National specifications for infection prevention and control and cleanliness were not adhered to, particularly in the gynaecology service. These included: requirements for hand washing facilities in Health Building Notice (HBN) 00-09: Infection control in the built environment, and the requirements for cleaning, cleaning schedules, and checklists set out in the Health and Social Care Act 2008: code of practice for health and adult social care on the prevention and control of infections and associated guidance. There were no handwashing sinks in the EGU. There was also no clean utility or treatment room or a dirty utility area in EGU. Staff had to use the facilities in the adjoining ward (S2) or in EPAU. This meant an increased risk of cross contamination.
- There were two dirty utility areas within the colposcopy and hysteroscopy outpatient department. In both of these rooms we saw that clean linen and clean dry clinical supplies including diathermy instruments were stored in boxes on the floor and that the cupboards contained clean instruments. We moved the boxes to one side and were not assured that the floor had been cleaned recently as it was dusty underneath the boxes and underneath the sink areas. There was no documentary evidence to show when the cleaning had last taken place and staff were unable to confirm when this happened. On our unannounced visit, we found segregation of clean and dirty areas and equipment had taken place, and the floor was clean. However a cleaning schedule was still not in place.
- We saw that the tops of cupboards in the treatment room in the gynaecology outpatient areas and inpatient areas were dusty and that the floors were dusty and stained. Privacy curtains in the treatment areas in the colposcopy and hysteroscopy treatment room, EGU treatment room on Ward S2, and EPAU were visibly dirty and were not labelled to show when they had last been cleaned or changed. Staff were unable to confirm when this had happened. We brought this to the attention of the senior nurse in each area. During our unannounced inspection the curtain in the treatment room on Ward S2 was replaced with a new disposable curtain.
- We saw a refrigerator in the dirty utility room in the colposcopy department was covered by a sheet, and on inspection saw that it contained food and drinks which we were told belonged to staff. None of the nursing or administrative staff we spoke with could confirm who it belonged to or account for this arrangement. We brought this to the immediate attention of the Head of Midwifery and Gynaecology Services who told us corrective action would be taken.
- We observed general compliance with the trust infection prevention and control policy. We saw staff used hand gel, protective clothing and mostly adhered to the bare below the elbow policy. However, we saw three members of midwifery staff wearing nail varnish and rings with stones. This meant patients were potentially at risk of cross infection.
- We saw that all areas of the maternity service we visited were visibly clean and well maintained. An external company was responsible for cleaning. We did not see evidence of cleaning or checklists in any of the inpatient or outpatient areas we visited. Staff confirmed they were not used.
- We saw the use of 'I am clean' labels attached to some equipment to show it had been cleaned on the maternity ward and delivery suite but not in the birth centre. Labels in the gynaecology inpatient or outpatient were attached but not dated or signed. This meant that staff were unable to confirm when cleaning had last taken place.

Maternity and gynaecology

- Dirty utility areas in maternity were clean and had appropriate disposal facilities, including for disposal of placentae.
- There was a dedicated room in the high dependency unit (HDU) on delivery suite for patients with known or suspected infections. Patients were screened for MRSA prior to elective caesarean section.

Environment and equipment

- We saw from the risk register that there was poor mobile signal within the maternity department which meant there was a risk that staff could not communicate with each other when necessary. It was not clear how long this had been on the risk register. The action plan was to develop a plan to improve mobile reception; a person was responsible for this and a date for completion was entered on the risk register. However, a system was in place for staff that are needed during an emergency to carry a bleep.
- Staff reported difficulty in hearing emergency bells on labour ward. This could lead to a delay in staff responding to a clinical emergency care being delivered in a timely manner. This was on the risk register. It was not clear how long this had been on the risk register. The action plan was to explore the possibility of having flashing lights inside the rooms and in theatre to alert staff to emergency. A person was responsible for this item and it should have been completed in April 2016; the completion date had not been met.
- We found equipment was generally clean and fit for purpose. However in the EGU we saw three out of seven of the recliner chairs were broken or heavily stained, we also saw a treatment couch with a tear in the cover in the treatment room on Ward S2 which was used by patients from EGU and patients using the gynaecology in-patient service. There was a tear in the stool used by staff when undertaking scanning procedures on EPAU. During our visit we brought these observations to the immediate attention of the nurse in charge, who told us that corrective action would be taken. We saw the treatment room couch was replaced during our announced inspection, the recliner chairs were removed, and evidence that the scanner stool had been reported and an order made for a replacement. We were told on our unannounced inspection new chairs had been commissioned and ordered.
- We also noted a torn couch in the triage area within maternity. On our unannounced inspection this was still the case. We brought this to the attention of the matron who told us that a new one had not yet been commissioned. We also noted the television in the waiting area remained out of use and no controls were available to operate it.
- Staff we spoke with were unclear about the procedures for labelling and replacing out of order equipment.
- Portable appliance testing (PAT) or external company servicing of all equipment we looked at was found to be in date, meaning that it was safe for use.
- The trust resuscitation policy stated that the emergency equipment trolleys were to be checked twice daily by checking a numbered seal was in place. Once a month staff were required to break the seal, check each item, and re-seal with a new numbered seal. We saw that this took place regularly.
- We saw that Resuscitaires (emergency apparatus for baby resuscitation) had been consistently checked since July 2016. We were not assured that regular checks were undertaken prior to this due to consistent gaps on the checklist.
- Telemetry (remote) cardiotocography (CTG) machines were available for women whose babies needed monitoring in labour, but did not want to be restricted to the bed. This helped promote normality. CTG machines are used to monitor the baby's heart rate and the frequency of contractions when a woman is in labour. This involves two straps being applied across the woman's abdomen that are attached to the machine and does restrict movement. Telemetry CTG machines are operated by Wi-Fi and enable women to be mobile.
- An intercom system was used to gain entry to the delivery suite, birth centre and the maternity ward to identify visitors and staff to ensure women and their babies were kept safe.
- Birth centre staff we spoke with knew pool cleaning and evacuation procedures which meant patients using the pool were safe from infection and could be removed from the pool in an emergency.

Medicines

Maternity and gynaecology

- Patients had access to medicines when they needed them. Medicines were supplied by the hospital pharmacy. There was a top-up service for replenishing medicines stock items and for other medicines issued on an individual basis. However, there was no clear audit trail for the request and receipt of medicines stock, and no formal audit to monitor medicines management against policy.
- Staff were clear about the arrangements in place for safely managing medicines. This included policies and processes for ordering, recording, storing, dispensing, administering and disposing of medicines.
- The clinical areas we visited had daily pharmacy presence on weekdays and had access to an on-call pharmacist out of hours. Individual prescriptions were monitored by pharmacists on a regular basis, who recorded their observations in patient records, and advised staff in the safe medicines management. All medicines including medical gases were administered only where prescribed by a doctor. Prescriptions were paper held.
- We saw allergies were recorded in patient records and the medicines administration records.
- Medicines including controlled drugs were safely and securely stored. Controlled drugs are medicines which require additional security. Records demonstrated that twice daily stock checks of controlled drugs were maintained and that these were correct. The most recent controlled drug (CD) audit carried out by the pharmacy (August 2016) gave low scores for delivery suite and maternity for the maintenance of their CD registers (36% and 57% respectively, the lowest in the trust).
- Emergency medicines used for the treatment of anaphylaxis or cardiopulmonary resuscitation were clearly labelled, available for use, and regularly checked.
- We found that the key to the controlled drug cupboard on the birth centre was not handed over when the service took possession of the new unit in 2013. Controlled drugs were therefore not stored on the birth centre. Staff told us they obtained controlled drugs from triage if a patient on the birth centre required pain relief in labour. This meant that two midwives had to leave the birth centre in order to carry out the required checking and administration of controlled drugs.
- We saw that non-luer-lock epidural infusion administration sets were in use for spinal or epidural procedures on delivery suite. A luer lock syringe enables a needle to be locked into place, providing a secure connection and preventing accidental removal of the needle as well as accidental injection of contents.
- This was on the risk register with a review date of 1 September 2016. The action plan was the 'procurement to source non-luer lockable epidural sets'; however there was no completion date. We were not assured this action would be completed in timely manner putting patients at risk.
- Medicines were not always correctly stored. We saw that ampoules of local anaesthetic were stored in an unlockable trolley on the corridor in the delivery suite. Intralipid (a liquid administered intravenously as a source of fat and energy, typically to patients who are unable to eat for prolonged periods of time) should be stored below 25°C. This was stored in a trolley, also on the corridor. The temperature of the corridor was not recorded and we were therefore not assured the substance would be safe for use.
- Temperatures of refrigerators used to store medicines were monitored daily and were all within the correct range. This ensured that medicines were maintained at the recommended temperature. However, where medicines were stored outside of the refrigerators there were no systems in place to monitor the room temperature. We brought this to the attention of the pharmacy team and were told that this was not routinely measured or checked on audits. The NMUH Storage and Security of Medicines Policy (June 2016) states that 'cupboards should not be sited where they may be subjected to higher than average humidity or temperature', but does not indicate any measurement of this.
- In the clean utility room on Ward S2 we saw nine ampoules of local anaesthetic stock items belonging to EGU that were not stored in their original packaging, and that had past the expiry date (June 2015). We brought this to the immediate attention of the nurse in charge, who arranged for disposal of the medicines.
- There was an up to date antibiotic protocol which included first and second choice medicines to use, the dosage, and duration of treatment.

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- For patients being discharged, tablets to take away (TTA) were delivered to the patient. If patients were given medicines as a TTA, they were given specific advice on how the medicines should be stored and handled.
- Staff received and acted on safety alerts relating to medicinal products and medical devices in a timely manner, and provided us with examples of where this happened.
- We saw that the nurse or midwife administering medicines was identified by wearing a red tabard. This indicated that they were not to be disturbed to allow them to concentrate on the administration of medicines.
- Midwives may supply and administer medicines under a system known as midwives' exemptions. We were told that sealed medicine packs were dispensed by the pharmacy for community midwives to supply and administer medicines where this system was in place. This was good practice and ensured the medicines had been checked for safe administration.
- At the time of our visit, women did not carry handheld notes until 16 weeks of pregnancy and therefore they and other healthcare professionals did not have access to their records until this time. We were told that this was because the notes were retained until information was entered onto the maternity management system. Community midwives told us they found this challenging as they did not have access to computers in clinics and children's centres and there were not any computers in their offices. Data was entered on available computers in the birth centre.
- On the maternity unit we saw individual maternity records being reviewed as part of the women's care and the red books were introduced for each new born in the postnatal transfer lounge. Red books are used nationally to track a baby's growth, vaccinations and development.

Records - Gynaecology

Records - Maternity

- We reviewed 10 sets of maternity notes and found variance in the quality of documentation. For example, safety care bundles, SBAR handover and VTE assessment were inconsistently completed. Not all patients had a Modified Early Obstetric Warning Score (MEOWS) chart completed and minimum data sets were missing in three out of four records where they should have been used (minimum data sets are used to identify patients and vital signs at commencement of a CTG). SBAR (Situation, Background, Action, and Recommendation) is a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety.
- The Supervisors of Midwives led a record keeping audit which confirmed our review of records; there was 75% compliance with SBAR used at handover and transfer of care and MEOWS charts completed with total score noted. An action plan was in place to address these shortfalls including training on the preceptorship programme, during Maternity Support Worker (MSW) and Health Care Support Worker (HCSW) induction and the introduction of an SBAR sticker. The action plan had allocated responsibilities and time lines.
- We saw that patient records in the gynaecology outpatient and inpatient service were stored securely.
- We reviewed 15 sets of care records within the gynaecology service, including for eight patients using the outpatient colposcopy and EGU and seven using the inpatient services. Records were formatted in a standard layout to allow ease of access to information. All the records we looked at were legible and contemporaneous. However, the VTE assessment, which appears on the NNUH medicines administration chart, had not been completed in two of the three records of patients undergoing early medical abortion for fetal abnormality, or for any of the patients using the gynaecology service.
- Patient records contained information of the patient's journey through the service, including assessment, investigations, test results, and treatment and care provided.
- For patients having gynaecological surgical procedures operating theatre records were completed and included the World Health Organisation (WHO) Safer Steps to Surgery checklist.
- Arrangements were in place to safeguard adults and babies from abuse, harm and neglect and reflected up to date safeguarding legislation and local policy. A safeguarding speciality midwife was in post to support midwives and patients with safeguarding processes.

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- There was a child and baby abduction policy in place to ensure the safety of babies whilst on trust premises. This included taking measures to ensure the security and prevention of baby/child abduction, as defined under the Child Abduction Act 1984.
 - Staff we spoke with demonstrated an understanding of the trust's safeguarding procedures and its reporting process and provided us with examples of when they or a colleague had raised a safeguarding concern. Staff spoke confidently about the arrangements in place and told us they felt supported by the safeguarding lead and medical staff in this context.
 - Midwives reported excellent support from the safeguarding midwife who visited the ward areas daily. Nurses in the gynaecology service told us they felt supported by the safeguarding lead and the obstetrics and gynaecology consultants.
 - A flag showed on the maternity information system for any woman who had a safeguarding concern to help alert staff to the concern. Any safeguarding plans were also uploaded to the information system.
 - If a woman who was not known to the service presented for treatment, staff informed the local safeguarding board who then made enquiries with the social services department in the woman's home locality.
 - The trust provided us with information that demonstrated 0.51% of patients have disclosed domestic violence. Following the inspection the trust told us all women booked are asked about domestic violence which was a mandatory field on the maternity midway. The trust told us that screening for domestic violence is 100% which is in line with NICE guidelines [PH50] Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively between May 2016 and August 2016. Staff knew how to make referrals to other agencies in cases of disclosure.
 - Safeguarding supervision is a Department of Health requirement (Working Together to Safeguard Children, 2010). A safeguarding case supervision policy was in date and community midwives undertook safeguarding supervision in line with trust policy.
 - Safeguarding training compliance at level three was recorded at 100%. Training included safeguarding patients at risk female genital mutilation (FGM); child sexual exploitation and trafficking.
- ## Mandatory training
- Staff explained they completed mandatory training in an effort to ensure safe care was provided. Mandatory training covered subjects including basic life support, conflict resolution, equality and diversity, fire safety, health and safety, information governance, moving and handling, and safeguarding.
 - Completion of mandatory training was monitored as part of NMUH's clinical governance processes. The overall compliance with mandatory training for gynaecology training staff was 98.33% and midwifery staff was 90.47 % compared to the trust target compliance of 90%.
 - Maternity specific mandatory training and other learning and development was managed by the practice development midwife and covered subjects including: antenatal screening, promoting normality in high risk women, infant feeding update and revalidation.
 - Practical Obstetric Multi-Professional Training (PROMPT) intrapartum training was in place for maternity staff to maintain their skills in obstetric emergencies including management of post-partum haemorrhage, breach presentation, shoulder dystocia (difficulty in delivery of the baby's shoulders), cord prolapse and CTG interpretation. We saw that 76% of registered midwives and 67% of obstetric consultants had attended this training between September 2015 and September 2016; we were told there is no agreed trust target for this training.
 - CTG machines were used by midwives on the delivery suite to measure contractions and the baby's heart rate over a period of time. Midwives were assessed for CTG competence in PROMPT training and those not meeting the pass mark were referred to their named supervisor of midwives for remedial work and reassessment. The trust told us post inspection that if medical staff failed the CTG training, this would be reported to the labour ward consultant lead and consultant education lead.

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The trust provided three different means of CTG training and staff are required to present their certificate before been allowed to independently practice CTG interpretation.

- In addition to CTG sessions in PROMPT, the trust used an online fetal monitoring package: data was provided that demonstrated 86% of midwives 82% of doctors had undertaken this training. A weekly CTG case review meeting was led by a Consultant Obstetrician.
- Agency staff were responsible for their own mandatory training. National Health Service Professionals used a system to ensure agency staff training was up to date. This protected patients from being cared for by staff who were not appropriately trained.

Assessing and responding to patient risk

- For women using the maternity services the booking visit took place before 12 weeks of pregnancy and included a detailed risk assessment. Administrative staff screened maternity referrals against an established protocol which means clinical risk may not be identified. However, there was a process and criteria in place for safe referrals management with escalation to midwifery staff for advice where there are concerns. We saw that 75% of patients had an antenatal risk assessment completed at booking between January 2016 and August 2016; the trust target was not provided. This meant that 25% of patients were not assessed and booked in for their first scan in a timely manner. On-going risk assessment was carried out at subsequent antenatal visits and referral to the obstetric team made if risk factors were detected.
- Patients were advised to attend their GP for vaccination against influenza and whooping cough. The trust were not auditing whether this advice was given to patients. This meant the level to which women and babies were protected from these infections was not monitored by the trust.
- Women who had problems in pregnancy were reviewed on the maternity assessment unit (MAU). From there they could be admitted to the ward for short periods of time to be reviewed regularly by the obstetric staff.
- A screening team was responsible for antenatal and newborn screening. The Regional Quality Assurance Screening Team for London and NHS England collects data on eight key performance indicators (KPIs) for screening including antenatal infectious disease screening - timely assessment of women with hepatitis B; the number of completed laboratory request forms for fetal anomaly screening; the number of women tested for sickle cell and thalassaemia; the number of women tested by 10 weeks gestation and the number of laboratory requests with completed Family Origin Questionnaire; the number of avoidable repeats for new born blood spot test; and the number of babies having Newborn and Infant Physical Examination (NIPE), including timely assessment of developmental dysplasia of the hip (DDH).
- Data provided by the trust demonstrated compliance with two KPIs: the number of women tested for sickle cell and thalassaemia, and the number of babies having Newborn and Infant Physical Examination (NIPE) timely assessment of developmental dysplasia of the hip (DDH) for April 2016 to June 2016 (Quarter 1 2016/17).
- Completion of the Family Origin Questionnaire (FOQ) allows healthcare professionals to assess whether an individual is a likely carrier for sickle cell disease and thalassaemia. The FOQ is relevant to the trust because the conditions are more common in people from some black and minority ethnic communities served by NNUH. The trust had 89.2% compliance with this KPI against the target of 95%. The trust recorded 'FOQ became mandatory on the maternity IT system from 1st July 2016, and this will be reflected in the next KPI'.
- There was 37% compliance with the KPI for the number of women tested for sickle cell and thalassaemia by 10 week's gestation against the target of 50%. The trust recorded 'Efforts to book women earlier have proved unsuccessful and we are aware further work is needed to ensure admin staff understand the importance of booking women by 10 weeks and not 12 weeks'.
- NIPE is the first examination of a baby completed within 72 hours of birth. The trust scored 93.4% against a target of 95% for this KPI. The trust recorded '87 babies in total did not have the NIPE check within the required timeframe. 69 babies within maternity did not have the NIPE check within 72 hours. This is disappointing and an urgent meeting between the head of midwifery, the NIPE lead and her matron, the ANNB screening coordinator and IT to be arranged as a matter of urgency. 18 babies were admitted to NNU, 4 of which were too unwell/premature to have NIPE within 72

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hours. The remaining 14 babies should have had the check within 72 hours. All 18 had the NIPE check before discharge home from NNU. Meeting to be arranged with NNU matron, NIPE lead midwife, consultant paediatrician by the ANNB screening coordinator to review the situation’.

- There was 1.4% compliance with the number of avoidable repeats for new born blood spot test which is better than the trust target of 2% -3%. The reasons included insufficient, compressed or contaminated samples, inaccurate completion of the form and use of expired cards. We saw that the screening team were monitoring this and midwives making errors were asked to complete the NSC e-learning module and bring a copy of their certificate to the screening team once completed. We saw that this happened.
- Community midwives were unable to access blood results in clinics or children’s centres and did not have computers in their offices. This meant they were not readily able to access investigation results which could impact upon a patient receiving timely intervention for conditions such as anaemia or urinary tract infections.
- We were told posters had been designed in different languages to inform women about the importance of changes in babies’ movements; these were not visible in the antenatal clinic or ward areas at the time of our inspection.
- Turkish link workers were in post and worked with staff to offer face to face interpretation. Midwives we spoke with were concerned that accurate assessments were difficult to obtain over the telephone interpretation and that interpreters did not have an understanding of medical language. However, we raised this with the senior management team who told us face to face interpretation was available. We saw this taking place in the gynaecology service.
- Maternity staff used the modified early obstetric warning score (MEOWS) to monitor women in labour and to detect the ill or deteriorating woman.
- Patients attended triage and were RAG rated according to reason for attendance using a form introduced shortly before our inspection. The RAG system is a method of rating the severity of a patient’s condition, based on Red, Amber (yellow), and Green colours used in a traffic light rating system.
- Red ratings included maternal collapse, vaginal bleeding, eclamptic fit, cord prolapse, chest pain or those admitted by ambulance who triggered on the MEOWS chart and were immediately transferred to the delivery suite. An amber rating indicated the patient should be assessed within 15 minutes and included patients presenting with calf pain, meconium stained liquor not in labour, moderate abdominal pain and raised blood pressure. Green rating required assessment within 30 minutes and included reduced fetal movements, mild abdominal pain, diarrhoea and vomiting, itching, fall or a ‘show’.
- The four bedded ‘Blue Bay’ was used for ambulatory induction of labour. This meant that patients attended triage for administration of propess (the medicine used to induce labour) and for monitoring then returned home to wait for labour to start.
- All women in early labour were seen and assessed on triage. Staff we spoke with told us that births frequently take place in triage. We were not assured that patients were being cared for in the right place at the right time, by adequate staff which put them at risk. However, the trust told us that in 2015 two women delivered in triage and no woman have delivered in triage in 2016. The trust told us it was possible that these relates to women who presented in late labour and that there was no adequate time to transfer them to either the Birth Centre or Labour ward. All midwives in triage were fully trained midwives and able to support in such situations. Triage had neonatal resuscitation equipment.
- There was a high dependency unit (HDU) on the delivery suite for patients requiring this level of care. We saw that patients were not always cared for in the appropriate place. For example we saw that a woman requiring high dependency care was not in the HDU. We witnessed this questioned by the consultant anaesthetist. Senior midwives said the patient was receiving one to one care so ‘it didn’t matter’.
- We saw evidence of a guideline for management of sepsis in the obstetric patient maternity which helped staff identify women at risk of sepsis and initiate required treatment.

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- We were told that the critical outreach team supported nurses and midwives with the care and management of critically ill patients. Any woman who needed additional support and care such as central venous lines was transferred to the intensive care unit (ICU).
- There were arrangements in place to ensure safety checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion of the World Health Organisation's (WHO) Five Steps to Safer Surgery' guidelines. Data provided by the trust showed 97% compliance with the WHO check list between January 2016 and September 2016; checklists showed that this was usual practice. During our visit, we saw this happened in practice for all the patients having gynaecology surgical procedures and that it had been fully documented in their records.
- NHS Safety Alert 1229: Reducing the risk of retained swabs after vaginal birth and perineal suturing states that swabs should be counted whenever they are used. Between January 2016 and July 2016, compliance with pre and post procedure swab and needle counts documented by two people was 76%. This meant that where it was not completed women were potentially at risk from a retained swab, which is a never event.
- The senior midwives on duty provided CTG review known as 'fresh eyes'. This was in accordance with NICE Intrapartum Guidelines. It involved a second midwife checking a CTG recording of a baby's heart rate to ensure that it was within normal parameters. A record keeping audit demonstrated 97% compliance with hourly CTG classification and that 98% of CTGs were monitored appropriately according to NICE Guidelines between January 2016 and July 2016.
- We saw documentary evidence of failure to monitor a patient in the postnatal period. The patient required bowel surgery after a caesarean section. The learning form this incident was for a daily consultant ward round to take place for high risk women on the postnatal ward.
- Staff told us the trust policy required thromboembolism (VTE) scores were monitored and recorded in all patient records, as recommended by NICE Clinical Guideline 92 Venous Thromboembolism: reducing the risk for patients in hospital, 2015. VTE is the term given to blood clots.
- VTE was not recorded on the dashboard and no staff of any grade could demonstrate compliance with VTE assessment during inspection. However, following the inspection the trust told us VTE are mandatory fields on maternity midway and reported on a quarterly basis to UNIFY. The VTE performance reported by the trust following the inspection for maternity between May and October 2016 was approximately 97%.
- However, during our announced inspection we reviewed seven sets of notes for patients using the inpatient gynaecology service and eight sets of notes for patients using the outpatient service. None of the patient records we looked at showed any documentary evidence of a VTE assessment being completed. Staff we spoke with confirmed they had not been carried out. Senior nurses acknowledged this had been a problem and that work was in progress to address the gaps.
- There were arrangements in place for the safe administration of blood and blood products set out in the NMUH Blood Transfusion Ward Protocol January 2015. This included a requirement that only registered staff who were qualified and authorised to administer blood would do so against a written order by the patient's clinician, and that observations of temperature, pulse and blood pressure would be carried out and documented at the start and completion of each unit of blood.
- During our visit we saw that the policy was not complied with in the case of one patient receiving a blood transfusion in the gynaecology inpatient services. Nursing staff we spoke with were unclear about whether the patient had received the completed transfusion, and there was incomplete documentary evidence of clinical observations. Nursing staff were unable to confirm the arrangements for handover to another appropriately trained nurse when the registered member of staff who was qualified and authorised to administer blood products left the ward area to take their break. We brought this to the immediate attention of the nurse in charge who told us that corrective action would be taken.
- In each of the clinical areas we visited a communication hand over took place at the change of each shift. Handover included a review of all patients, safety reports, staffing levels and allocation of work. Formal multi-disciplinary handovers carried out twice a day on the delivery suite attended by medical staff and the labour ward coordinator.

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- We observed the 7.30 am handover for gynaecology inpatients and saw it was structured following 'SBAR'. Care was assessed and planned at this handover and work allocated to the appropriate nurse.

Midwifery staffing

- Birthrate Plus® is a midwifery workforce planning tool which demonstrates required versus actual staffing need to provide services. Birthrate Plus® is recommended by the Department of Health; endorsed by the Royal College of Midwives and incorporated within standards issued by the NHS Litigation Authority. It enables the workforce impact of planned change(s) to be clearly mapped, in order to support service improvement and planning for personalised maternity services.
- A Birthrate Plus® assessment was carried out in January 2015. It recommended that the trust required 168.53 WTE clinical midwives which excluded managerial and specialist roles.
- The budgeted establishment for the midwifery workforce was 143.96 whole time equivalent (WTE) clinical midwives excluding managerial and specialist roles. We saw that 163.41 WTE clinical hours were worked in April 2016. The vacancy rate was 8.6 WTE and the sickness rate was 2.5% WTE. Agency and bank staff were used to fill shortfalls.
- To mitigate this risk, the HoM had presented a paper to the board in September 2016 to approve an additional 12.7 WTE midwives. Maternity staffing was on their risk register.
- We saw that the midwife-to-birth ratio was 1:32 (one midwife to 32 births). This was less than the national average of 1:28. In August 2016 90% of patients received one to one care in labour and 84% in September 2016 which was not in line with national guidance. This meant that 10-16% of women were not receiving one to one care in labour.
- NICE Guidance NG4: safe staffing for maternity settings states 'a midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs (the inability to provide 1:1 care in labour for less than 90% of women in established labour for less than two hours), the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed'.
- The Head of Midwifery told us that the maternity services did not use an acuity tool. However, we saw that an acuity tool to assess workload and capacity in the maternity unit was used four hourly by the labour ward coordinator. Capacity was assessed four hourly and rated as red, amber or green; an escalation policy was in place. When a red flag event was identified, the manager and supervisor of midwives on call were contacted; out of hours the on-site manager was contacted. Specialist midwives were utilised to support delivery suite and the community midwives were called in to release Birth Centre midwives so they could go to delivery suite. However, community midwives were not clear about their role in the escalation policy. Their understanding was that they were on call for babies born before admission to hospital (BBAs) only and told us the policy 'kept changing'.
- We noted on our inspection that a red flag should have been identified and the escalation policy initiated. High activity and acuity, which was not escalated in line with NMUH policy, was also recognised as a contributory factor in a serious incident. We were not assured the service was recognising and acting on increase in activity in order to keep patients safe.
- Midwives worked 11 hour shifts and had a 1.5 hour break. A delivery suite coordinator requires constant oversight of the ward so that decisions could be made regarding care and treatment. We saw that the delivery suite coordinator was not always supernumerary and staff confirmed this; in times of high acuity they had to assume care of patients. This could impact negatively on the safety of women in labour because the co-ordinator needed to have an overview of activity at all times in order to manage the ward safely.
- The planned and actual staffing levels were displayed at the entrance to each maternity ward. The delivery suite required eight midwives and two maternity support workers (MSW) on each shift. We saw that required and actual staffing was met during our inspection. In addition, one midwife was allocated to theatre Monday to Friday along with two registered nurses (RNs) and one Health care support worker (HCSW) to cover the elective caesarean list. However, there was reliance on agency staff to achieve the required staffing; we saw evidence that up to three agency midwives could be on one shift.
- Senior managers told us that due to agency double booking staff, the service could be left short staffed on the day with no opportunity to fill vacant shifts.

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- Staffing requirements for the maternity ward was three midwives, one registered nurse and four MSWs on the day shift and three midwives and two MSWs on the night shift. We saw that required and actual staffing were met on this ward. In addition one nursery nurse was required and this post was filled by one MSW at the time of our visit. Staff on the maternity ward told us they often had to work on the delivery suite when it was busy.
- Staffing requirements for the birth centre was two midwives and one MSW. We saw evidence that when women were transferred from the birth centre to delivery suite the midwife would stay with the patient on delivery suite leaving the birth centre with only one midwife.

Nursing staffing

- Patients requiring the inpatient gynaecology service were cared for by nurses in a general surgical ward.
- Planned and actual staffing levels for gynaecology patients were not displayed. We were told that the service met actual staff ratios for each shift. Nurses working in the gynaecology outpatient services were supported by health care support workers and administrative staff, with the exception of EGU where no dedicated administrative support was provided.

Medical staffing

- The trust employed 44.1 WTE medical staff in the maternity and gynaecology services. The level of consultant cover was 40% which is the same as the national average. The percentage of registrars 40% which is fewer than the national average of 46%. The percentage of middle grade doctors was 15% which is greater than the national average of 8%. There were 5% junior grade doctors which is similar to the national average of 6%.
- Consultant obstetric cover on the delivery suite was on average 98 resident hours per week. There were 15 consultants and at the time of the inspection. The consultant staff stayed on the delivery suite every day from 8.00am until 10.00pm. Out of hours cover was provided by the consultant on call from 10.00pm until 8.00am. At weekends, the on call consultant covered both maternity and gynaecology. All consultants were within 30 minutes transfer time of the hospital.

- There were twelve registrars and twelve junior grade doctors who covered the maternity and labour ward over a 24 hour period; a junior trainee and a registrar during were on duty during the day and a registrar at night.
- The gynaecology service was covered by a junior trainee and a registrar during the day and a registrar at night. Emergency gynaecology surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) by consultants and/or middle grade staff; emergency gynaecological surgery took place during the first hour of the NCEPOD list.
- The maternity service had approved safe staffing levels for obstetric anaesthetists and their assistants, which were in line with Safer Childbirth (RCOG 2007) recommendations. There was 24-hour senior anaesthetic cover for labour ward.

Major incident awareness and training

- Staff were aware of the procedures for managing major incidents and fire safety incidents.

Are maternity and gynaecology services effective?

Good



We rated effective as good because:

- Staff had access to and used evidence-based guidelines to support the delivery of effective treatment and care.
- Termination of pregnancy for fetal abnormality was offered in line with legal requirements and professional guidance.
- Women we spoke with felt that their pain had been well managed. Epidurals were available over a 24-hour period.
- Access to medical support was available seven days a week. Community midwives were on call 24 hours a day to facilitate the home-birth service.

However:

- The trust was offering group sessions for the first antenatal appointment known as the 'booking' appointment.

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- Patients did not have a named midwife.
- We were not assured that the audit process was robust or consistent.
- The trust was not using customised growth charts to monitor fetal growth.
- We were not assured the service was monitoring and evaluating stillbirth rates to make improvements.
- We found that multidisciplinary team (MDT) working was not always effective in the maternity service.

Evidence-based care and treatment: Maternity

- Policies were based on national guidance produced by NICE and the royal colleges. Staff had access to guidance, policies and procedures via the trust intranet.
- To ensure compliance with NICE guidance, the trust regularly benchmarked their guidelines against those of NICE. For example we saw a baseline assessment tool that demonstrated full compliance with eight out of 14 guidelines. Six guidelines were partially compliant and action plans were in place to address shortfalls.
- The care of women using the maternity services was in line with Royal College of Obstetricians and Gynaecologist guidelines (including Safer Childbirth: minimum standards for the organisation and delivery of care in labour). These standards set out guidance in respect to the organisation and include safe staffing levels, staff roles and education, training and professional development, and the facilities and equipment to support the service.
- We found from our discussions and from observations that care was being provided in line with the NICE Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care.
- Triage of referrals was allocated to administrative staff without clinical input. This meant that that vulnerable and high risk woman may not be identified in a timely manner and receive the appropriate level of care for their needs.
- The booking appointment is the first appointment with a midwife when medical, obstetric and social histories are recorded, risk assessments carried out, options discussed and plans made for pregnancy. We found that the trust was carrying out two group booking sessions in which eight patients attended clinic and were provided with information about their care and treatment followed by individual assessment with the midwife. Criteria for the sessions included patients with low risk pregnancies and those with English as their first or second language. Such groups were introduced to enable groups of women to meet.
- Senior midwives told us 16 English speaking (first or second language) women with low risk pregnancies were invited to group booking sessions which held on Saturdays. However, staff who managed the sessions reported that groups did not meet the trust criteria which meant that the effectiveness of the group booking was reduced. For example, patients who did not speak English attended sessions which made it difficult to provide information to the group.
- Women were not booked under a named midwife but by 16 weeks of pregnancy were allocated to clinics closer to their homes and tended to see the same midwife thereafter.
- We found some evidence to demonstrate that women were being cared for in accordance with NICE Quality Standard 190 Intrapartum care. This included having a choice as to where to have their baby, care throughout their labour, monitoring during labour and care of the new born baby.
- We saw from our observation of activity and from reviewing care records that the care of women who planned for or needed a caesarean section was mostly managed in accordance with NICE Quality Standard 132. However, we saw that delayed cord clamping was not practiced and skin to skin did not take place.
- A vaginal birth after caesarean section (VBAC) clinic was held by the supervisors of midwives aimed at reducing the caesarean section rate.
- There was evidence to indicate that NICE Quality Standard 37 guidance was being adhered to in respect to postnatal care. This included the care and support that every woman, their baby and, as appropriate, their partner and family should expect to receive during the postnatal period. On the postnatal ward staff supported women with breast feeding and caring for their baby prior to discharge.

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- We found from our discussions and from observations that care was being provided in line with the NICE Clinical Guideline (CG110) Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors. This guideline covers the care of vulnerable women including teenagers, substance misuse, asylum seekers and those subject to domestic abuse.

Evidence-based care and treatment: Gynaecology

- Gynaecological surgery was undertaken on a day case or inpatient basis.
- The hospital collected data related to surgical site infections for breast surgery, knee and hip replacements, repair of fractured neck of femurs and caesarean section. However it was not analysed and used as a quality indicator to facilitate learning and prevention of potential infections. The hospital told us there were only nine surgical site infections in 2015/2016, all related to caesarean sections.
- Depending on the stage of pregnancy patients needing termination of pregnancy for fetal abnormality could be cared for in the gynaecology unit up to mid trimester (14-24weeks): medical termination of pregnancy. All women were followed up by the bereavement midwife. This offered continuity of care for the women if she wanted it.
- Choice was offered in line with RCOG Evidence-based Clinical Guideline Number 7: The Care of Women Requesting Induced Abortion. Following consultation in a designated fetal medicine clinic, women could choose to have early medical abortion (EMA), late medical abortion up to 18 weeks of pregnancy. Women requesting surgical abortion were referred to another provider of abortion services.
- There was evidence from information reviewed and from discussion with staff that the service adhered to The Abortion Act 1967 and Abortion Regulations 1991. This included the completion of the necessary notification to the department of health chief medical officer, known as HSA1 and HSA4 forms. A discharge letter was given to women providing sufficient information to enable other practitioners to manage complications in line with DH RSOP 3: Post procedure.
- The service provided us with the clinical audit plan for 2016/18 which showed 46 obstetric audits and seven gynaecology audits listed. Examples of audits included caesarean section, multiple pregnancy, amniocentesis and women over 40. Gynaecology audits included colposcopy, ectopic pregnancy and hyperemesis (excessive vomiting in pregnancy).
- All audits were registered with the trust audit department where a trust wide spreadsheet of audit was maintained. At the time of our inspection MEOWS charts, risk assessment, record keeping, intrapartum assessment, birth centre CTG, birth centre activity and waiting times in triage were on the register.
- New NICE guidelines initiated an audit to ensure the service is compliant. The audit midwife informed us that trends identified from risks and incidents inform the audit programme. For example MEOWS charts and caesarean section audit as a result of red RAG rate on the dashboard in 2015.
- The trust actively participated in national audits including the National Screening Committee antenatal and new born screening audit, the National Diabetes in Pregnancy Audit, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRACE), and a national endometriosis audit.
- An audit and guideline meeting was held monthly. An audit afternoon was held bi-monthly for all staff and audit was reported on at the labour ward forum to the multidisciplinary team.
- Completed audits and action plans were reported to the trust audit department and presented to the maternity risk meeting.
- We were not assured that the audit process was robust or consistent. For example a table top review of data about neonatal admissions had been undertaken and a stillbirth report was presented to the trust board in May 2016; both of which were reports and not audits.
- We were shown the post caesarean section surgical site infection audit March 2014 – March 2015 which was presented to the audit meeting on 20 November 2015. We saw recommendations and the action plan.

Audit

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However, the recommendations had not been completed and the audit midwife could not confirm the status of the recommendations; the person who led the audit would hold this information.

- In February 2016, the 26 recommendations of Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRACE), a national report on perinatal deaths for births from January to December 2014, were reviewed by a multidisciplinary team of Obstetricians, Paediatricians and Midwives at the trust to establish compliance with recommendations. The trust did not provide us with documentary evidence of compliance with the report. However, they told us 'Following the most recent MBRACE report we have nominated 2 perinatal mental health 'champions' and are compliant with the recommendation that the 'sepsis 6' protocol is commenced within an hour for all women attending with signs of sepsis'. (Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis).
- The government National Maternity Review report, Better Births, published in February 2016 made recommendations based on seven themes: personalised care, continuity of carer, safer care, better postnatal and perinatal mental health care, multi-professional working, working across boundaries and a fairer payment system. The trust did not provide evidence that it had benchmarked itself against the recommendations; it provided a Continuity of Midwife Care Audit led by the London Maternity Strategic Clinical Network in which it participated.
- The Morecambe Bay Investigation was established by the Secretary of State for Health in September 2013 following concerns over serious incidents in the maternity department at Furness General Hospital (FGH). The report made 44 recommendations for the trust and wider NHS, aimed at ensuring the failings are properly recognised and acted upon. We saw documentary evidence that NNUH had monitored its performance against the recommendations of the report and assessed that it was compliant with all but one recommendation: better postnatal and perinatal mental health.

Pain relief

- Women we spoke with in the maternity and gynaecology services felt that their pain and administration of pain relieving medicines had been well managed. Medical staff were available to prescribe pain relieving medicines where required and stocks of pain relieving medicines were readily accessible.
- Patients' perception of pain was measured using a recognised assessment tool.
- On the maternity ward we saw a variety of pain relief methods available including Tens machines, and Entonox :a ready to use medical gas mixture of 50% nitrous oxide and 50% oxygen that provides short term pain relief. Epidurals were available 24 hour a day.
- A birth pool was available on the delivery suite so women could use water immersion for pain relief in labour.

Nutrition and hydration

- A breast feeding specialist midwife was responsible for parent education. The trust promoted breastfeeding and the health benefits known to exist for both the mother and her baby. The trust policy aimed to ensure that the health benefits of breastfeeding and the potential health risks of artificial feeding were discussed with all women to assist them to make an informed choice about how to feed their baby.
- NNUH had been awarded and maintained UNICEF Baby Friendly Initiative stage two accreditation in May 2016 and was working towards assessment for stage three accreditation in May 2017. This meant that NNUH supported women and babies with their infant feeding choices and encouraged the development of close and loving relationships between parents and baby.
- The breastfeeding midwife had introduced a feeding assessment tool which was audited monthly.
- Women told us that they received support to feed their babies. We saw that the initiation of breast feeding rate was 92% between April and September 2016 which was better than the national average of 75%.
- We saw that patients' nutrition and hydration needs were assessed and met. Patients could be referred to a dietician if needed.

Patient outcomes: Maternity

- There was a maternal death in April 2016, which was not recorded on the dashboard.

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- The normal delivery rate, homebirth and baby born before admission (BBA) rates were not recorded on the dashboard. We saw documentary evidence for April to August 2016 that demonstrated the normal delivery rate was 50.3% (1156), which is less than the RCOG recommendation of 60%. The homebirth rate was 1.2% (28) which was below the national average of 2%. There were 16 births (0.7%) in other locations which included births before arrival (BBA), births in ITU, tertiary theatres or wards which does not include acute labour ward.
- Data was collected on the Maternity Scorecard. However the scorecard did not have the trust targets listed. The Maternity Scorecard for January 2016 to August 2016 demonstrated that:
 - The caesarean section rate was 26.6% which was greater than the national average of 25%.
 - Of these 10.3% were elective, which was similar to the national average of 10.7%. The emergency caesarean section rate was 16.8% which was greater than the national average of 14.7%.
 - The induction of labour rate was 22.9%, which was similar to the national average of 22%.
 - The Ventouse delivery and forceps rate was 12%.
 - The third or fourth degree tear rate for normal births was 2.5% and 4.4% for instrumental births. However, this had peaked for instrumental births in January and February 2016 at 11% and 12% respectively.
 - The major postpartum haemorrhage was 2%.
 - 4.5% of term babies were admitted to SCBU within a day of birth. The rate for babies diagnosed with Hypoxic-ischaemic encephalopathy (HIE) was 2.3%, greater than the trust target of 0.5%. HIE is a lack of oxygen and/or blood flow getting to the baby from the placenta during the birthing process.
- In 2015 there were 34 stillbirths out of 5,022 births, giving a rate of 6.7 per 1,000 live births. This was above the average of 4.7 per 1,000 for England and higher than the London rate of 5.5 in 2013. More recent figures provided by the trust indicate that the rate up to May 2016 was 4.4 which was slightly lower and better than the national average of 4.7.
- We were not assured that the trust was effectively continuing to ensure further reductions in the number of stillbirths. There was no action plan in place for us to see to address the stillbirth rate. On a number of occasions we were told the stillbirth rate was due to the demographics of the community the service provides care to and when we met with the management team we were told the stillbirth rate at NMUH was no worse than the London average. Furthermore, the notes on the Maternity Scorecard indicated that exception reports were carried out when other indicators scored red, for example emergency caesarean section for first time mothers, and term admission to the neonatal unit (NNU). Maternity reported on a quarterly basis into the CQRG and a report was submitted to CQRG in May 2016 that included a report into the high still birth rate. For the period of September 2016 to October 2016 the score for stillbirths was green and did not require an additional exception report.
- A report was submitted to the trust board in May 2016 (Report into antepartum stillbirth 1/1/12 – 31/12/2015) that made several recommendations including: urgent implementation of Gestation Related Optimal Weight (GROW) software; routine training of all midwifery and obstetric staff in correct measurement and plotting of symphysis-fundal height measurements; the introduction of multi-lingual information for parents about monitoring and reporting fetal movements; and improved use of interpreters for non-English speakers.
- Fetal growth restriction is associated with stillbirth, neonatal death and perinatal morbidity. Confidential enquiries have demonstrated that most stillbirths due to fetal growth restriction are associated with suboptimal care and are potentially avoidable. Tools for assessment of fetal growth and birthweight by defining each pregnancy's growth potential are available through GROW software.
- NHS England's 'Saving babies' lives' care bundle (2014) for stillbirth recommends measuring and recording fetal growth, counselling women regarding foetal movements and smoking cessation, and monitoring babies at risk during labour. Customised assessment of birthweight and fetal growth is recommended by the RCOG (Small-for-Gestational-Age Fetus, Investigation and Management Green-top Guideline No. 31).
- We saw that customised fetal growth charts were not in use to help identify babies who were not growing as well as expected. Two midwives had been trained in the use of GROW, one of whom had left the trust. Senior managers told us that a business case would be presented to the board for the funding required to

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implement customised growth charts. A research midwife had been appointed to lead on the implementation and all midwives would be trained in undertaking symphysis-fundal height measurement by June 2017. This was on the risk register.

Patient outcomes: Gynaecology

- Examinations, scans, treatment plans and assessments were carried out in the gynaecology outpatients and early pregnancy assessment unit (EPAU) during the week. A team of staff supported patients in investigative procedures, giving advice as necessary. Emergency scans and assessments were also available out of hours. We were told that there was gynaecology surgery scheduled on most days.
- The trust provided activity data for January 2016 to August 2016 that demonstrated the following:
 - 1,895 referrals to the gynaecology service
 - 3,839 outpatient appointments
 - 134 elective split-spell discharges
 - 556 day case split spell discharges
 - 588 non elective split spell discharges
- There were 41 medical terminations of pregnancy for fetal abnormality between April 2015 and April 2016.

Competent staff

- We saw evidence of induction and training for band 5 and newly appointed band 6 midwives and nurses, including for agency staff working in the gynaecology outpatient service. However, agency midwives we spoke with told us they had not had adequate induction to carry out their role. For example, they had not been shown where equipment was stored.
- All newly qualified midwives undertook a 12-month preceptorship period prior to obtaining a band 6 position and were supported by a lead midwife for preceptorship. This meant that they were competent in cannulation and perineal suturing and had gained experience in all areas of the maternity service.
- From November 2015 a Paediatric Deanery directive prohibited Paediatric SHO's to undertake the Newborn and Infant Physical Examination (NIPE), which has to be carried out within 72 hours of birth.
- Twenty-five midwives had been trained in NIPE. Succession planning was in place and a further two midwives were booked to undertake the course in October 2016.
- NMUH scored 77.5% for support and supervision of junior doctors compared to the London average of 78.7% and the national average of 80.9%. The score for obstetric training was 80% compared to the London average of 77.1% and national average of 77.7%. The score for gynaecology training was 66% compared to the London average of 63.6% and national average of 67.1%.
- An information pack and competency guide was provided to maternity support workers (MSWs) on appointment. This included guidance on activities they may undertake and a competency framework to confirm achieved competencies necessary for their role, such as taking and recording of vital signs, new born blood spot screening and cannulation.
- Nursing staff generally spoke positively about the learning and development opportunities provided and were required to maintain an individual record of continuing professional development activities as part of the Nursing and Midwifery Council (NMC) revalidation. Nurses we spoke with correctly described their individual role and the support provided by the service in ensuring that the revalidation requirements would be met.
- In addition to mandatory training some nurses had completed additional specialist training. For example nurses working in the colposcopy and hysteroscopy clinics told us they had completed additional specialist training in that area. Nurses working in the EPAU had completed ultrasound scanning training and training in counselling skills. An advanced nurse practitioner in surgical nursing told us they had completed diagnostic and assessment training.
- Nurses caring for people using the gynaecology services told us they were expected to provide emotional support and counselling for patients but had not had any specific training in this area. One nurse told us they had requested this over a year ago but that no training had yet been arranged.

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- Appraisal rates for staff were provided for us and these demonstrated that 95% of nursing and midwifery staff and 100% of medical staff had been appraised compared to the trust target of 90%.
- The function of statutory supervision of midwives is to ensure that safe and high quality midwifery care is provided to women. The NMC sets the rules and standards for the statutory supervision of midwives. Supervisors of Midwives (SoMs) were a source of professional advice on all midwifery matters and were accountable to the local supervising authority midwifery officer (LSAMO) for all supervisory activities.
- The NMC Midwives Rules and Standards (2012) require a ratio of one SoM for 15 midwives. During inspection we saw that the SoM ratio was 1:19 (London LSA Report 2015) which means that there were not enough SoMs to support midwifery practice, identify shortfalls and investigate instances of poor practice. However, following the inspection we saw in the new published report (London LSA Report 2016) that the SoM ration was 1:12 which shows there was enough SoMs to support midwifery practice.
- Midwives reported having access to and support from a SoM 24 hours a day seven days a week and knew how to contact the on-call SoM.

Multidisciplinary working

- A multidisciplinary handover took place twice a day on the delivery suite and included an overview of all maternity patients. We observed one midwifery handover where staff constantly interrupted by entering the room. During this handover, we witnessed senior midwifery staff who did not know the names of staff on shift and who made little eye contact with colleagues. The coordinator did not stay for the handover where patient care was discussed and discharges planned; this meant that hand over was not multidisciplinary.
- Relevant staff from the maternity and gynaecology services informed community midwives and GPs when a woman had suffered a pregnancy loss. They also immediately informed the obstetric administrative staff so that ongoing appointments could be cancelled.
- Communication with community maternity teams was efficient around discharge of patients. However, community midwives could not easily contact antenatal

clinic or MAU by telephone and frequently had to make appointments for women on return to the hospital which meant patients may not be seen in a timely manner. In the community we were told of effective multidisciplinary team work between community midwives, health visitors, GPs and social services.

- Senior managers told us that a consultant obstetrician was linked to each team of community midwives; midwives could not confirm this.

Seven-day services

- Access to medical support was available seven days a week.
- Community midwives were on call over a 24 hour period to facilitate home births.
- Postnatal clinics were available every day which meant babies received their first examination before 72 hours of age.
- The gynaecology outpatient services did not provide a seven day service. However, emergency care was available via accident and emergency out of hours.

Access to information

- NMUH intranet and e-mail systems were available to staff which enabled them to keep pace with changes and developments elsewhere in the trust, and access guidelines, policies and procedures to assist in their specific role.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that the patient consent was reviewed prior to surgical procedures. Consent was documented in line with the trust's policy.
- Staff we spoke with were aware their responsibilities in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

Are maternity and gynaecology services caring?

Requires improvement 

We rated caring as requires improvement because:

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- Patients' privacy and dignity were not always protected.
- Staff did not always address patients in the appropriate manner.
- Patients, partners and relatives did not always feel involved in their care.
- The results for the NNUH CQC Maternity Survey of Women's Experience of Maternity Services 2015 were worse than other trusts for all indicators for the labour and birth and staff during labour, and birth section of the report. Results were about the same as other trusts for care in hospital after birth.
- There was no provision for privacy for patients arriving in triage to discuss reason for attendance. Furthermore, we observed clinical care carried out in the waiting room.
- We observed disrespectful interaction between staff and patients in triage. Staff referred to patients as 'mummy' and addressed the partner rather than the patient directly.
- Staff helped people to cope emotionally with their decisions, care and treatment. However, there was no quiet room in EGU other than shared facilities with the surgical ward. There was limited evidence of staff training in providing emotional support.
- Women and their supporters were mostly positive about the care they had received in the delivery, maternity and gynaecology services.

However:

- The majority of women and those close to them were positive about the care and treatment they had received. Women were able to telephone Maternity Direct in working hours and triage out of hours for emotional support.
- A bereavement midwife saw all patients who experienced pregnancy loss, including visits at home if required.
- The trust had a chaplaincy team who were available to provide pastoral and religious support to patients and their families.

Compassionate care

- Privacy and dignity were not always maintained. In the EGU patients were cared for in recliner chairs in a shared lounge with an open door from a corridor which was a point of access to a general surgical ward and the EPAU. There were no screens between each chair area or on the windows between the seating area and the corridor which we saw meant that visual and auditory privacy were not always achieved. The chairs were in close proximity to each other as well as the communication station used by staff. There was a separate room for partners and supporters to wait in, however there were no facilities such as refreshments or allocated toilets.
- We saw documentary evidence that a labour room door was wedged wide open with a chair, because the room was extremely hot. Although the curtain in the room was drawn across to maintain the patient's privacy, it was drawn back and forth as the staff required to assist the delivery entered the room.
- Parents who had used the service before told us "everything has been great and really good"; they described staff as "caring, helpful and explained everything that was going on". Another patient told us that staff were "helpful, compassionate and comfortable to speak to", which was an improvement on staff attitude when she attended the hospital three years ago.
- However, some patients reported a different experience. Comments included "the treatments were not too bad but they can do better"; "some staff have shown encouraging, sensitive and supportive attitude while other do not care"; "most of the staff including the doctors have been compassionate while others stick to their job".
- The Friends and Family Test (FFT) results between June 2015 and April 2016 were similar to the England average for the antenatal period and postnatal community questions. The percentage of people recommending the birth was also similar to the England average. The percentage of people who would recommend the postnatal ward varied between none and 100% with lower than the England average between October 2015 and February 2016.
- The results for the NNUH CQCs Maternity Survey of Women's Experience of Maternity Services 2015 were worse than other trusts for all indicators for the labour and birth and staff during labour, and birth section of the report. Results were about the same as other trusts

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for care in hospital after birth. An action plan was in place and had been presented to the NNUH Board in May 2016. We reviewed the action plan and noted many of the actions are either due or overdue.

- Women we spoke with felt that there were not always enough staff to meet their individual needs.

Understanding and involvement of patients and those close to them

- We received differing views on understanding and involvement in care. Whilst some patients told us that they felt well informed and able to ask staff questions if they were unsure of anything, other were not well informed and felt the staff were not approachable.

Emotional support

- Women were able to telephone Maternity Direct in working hours and triage out of hours for emotional support.
- Midwives screened women for anxiety and depression levels.
- Women's wishes and choices were respected and their beliefs and faith were taken into consideration including regarding the disposal arrangements for fetal tissue.
- A bereavement midwife saw all patients who experienced pregnancy loss, including visits at home if required.
- The trust had a chaplaincy team who were available to provide pastoral and religious support to patients and their families.

Are maternity and gynaecology services responsive?

Requires improvement 

We rated responsive as requires improvement because:

- Efforts had been made to improve the flow of patients through maternity, although we were not assured that flow through triage to the labour ward was safe.
- There were long waiting times in triage. We saw that a patient waited for 50 minutes before being seen.

- Staff told us that patients could be in triage for up to seven hours in labour due to the lack of capacity or the willingness of the midwives on labour ward to accept women.
- Beds for patients using the inpatient gynaecology service were not solely allocated to patients requiring gynaecology care and therefore patients were only admitted to the surgical ward if there was space.
- Staff told us that patients experiencing miscarriage should be nursed in an individual side room, however they could not guarantee the room would be available at all times.
- Staff told us patients using the gynaecology service were generally seen promptly for treatment, however, this was not formally monitored.

However:

- The maternity service was flexible and provided choice and continuity of care. Patients' individual needs and preferences were considered when planning and delivering services.
- The individual care needs of women at each stage of their pregnancy were acknowledged and acted on as far as possible. There were arrangements in place to support patients with particular needs.
- Complaints about maternity and gynaecology services were initially managed and resolved locally. If complaints could not be resolved at ward level, they were investigated and responded to appropriately.

Service planning and delivery to meet the needs of local people

- Essential pre-treatment blood tests and treatment could generally be accessed in a timely manner.
- Women could access the maternity and emergency gynaecology services via their GP or by contacting the community midwives or service directly.
- Post-natal follow up care was arranged as part of the discharge process with community midwives and, where necessary doctors. The red book was issued on transfer to the postnatal ward and facilitated on-going care and monitoring of the baby until five years of age.
- There were some nurse led colposcopy and hysteroscopy services.

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Access and flow: Maternity

- The maternity unit had not closed between January 2016 and August 2016.
- Although efforts had been made to improve the flow of patients through maternity, we were not assured that flow from triage to the labour ward was safe and effective.
- Women could access the maternity service via their GP or by direct referral. During the inspection we saw that 77% of women were seen by a midwife by 12 weeks and six days of pregnancy against the trust target of 80% in August 2016. NICE guidance recommends that women are seen ideally by 10 weeks of pregnancy so that the early screening for sickle cell disease and thalassemia should be offered as early as possible in pregnancy. Also, this allows for early screening of Down's syndrome, which must be completed between 11 weeks zero days and 13 weeks six days of pregnancy as advised by NICE guidance. However, the trust told us following the inspection that 83% of women were booked before 12 weeks and six days in September 2016.
- We were told about and saw written documentation which confirmed women were supported to make a choice about the place to give birth. Women discussed their choice regarding place of birth and birth plans with their midwife at the 36 week antenatal appointment. We saw that specific risk factors were taken into account which needed to be considered and would lead midwives to advise a hospital rather than a home birth.
- Staff and patients reported long waiting times in antenatal clinic. We were told that women often sit on the floor in clinic because there are not enough chairs to cater for the size of the clinic, for example up to 140 women could attend the clinic on a Wednesday. There were no boards displaying the clinics in progress or the waiting times for each clinic.
- Elective caesarean section lists ran Monday to Friday with up to three operations on each list. However, we noted an incident where two elective caesarean sections were carried out on a Saturday which were both booked without planning. This put the patients at risk because the necessary staff were not available.
- A dedicated telephone service, Maternity Direct, was available between 10am and 6pm daily. Women were provided with the telephone number and could access it directly if they had any concerns. An experienced midwife managed the telephone and directed calls to the appropriate department. Triage took telephone calls out of hours.
- The Maternity Day Unit (MDU) provided an assessment service to patients between 8am and 8pm Monday to Saturday on an appointment basis. Patients could be referred to the MDU by all departments in the maternity unit, community midwives, GPs, or they could self-refer. Between 25 and 35 patients were seen on MDU each day. Day care was available for women with concerns such as reduced fetal movements. The MDU was run by two midwives and one support worker. Medical cover was provided by a dedicated obstetrician between 9am and 5pm. The on call team obstetric team provided cover after 5pm. Women were seen on the triage unit out of hours.
- There was a designated triage area open 24 hours each day where women with urgent complaints could be reviewed and assessed on an appointment basis. The waiting room had nine chairs. All women who were in labour were assessed on triage. A four bedded bay in triage was used for the ambulatory induction service. Triage was staffed by one midwife and a maternity support worker. Medical support was provided by a junior doctor. There was no clerical support to answer the doorbell or telephone. On our unannounced inspection we waited for three minutes for the doorbell to be answered which was answered by a junior doctor.
- We observed triage for a period of one hour and 25 minutes. During this time we spoke with a patient who had been waiting longer than 30 minutes and did not know when she would be seen. We saw that another patient waited for 50 minutes before being seen.
- Staff told us that patients can be in triage for up to seven hours in labour due to the lack of capacity or the willingness of the midwives on labour ward to accept women. They also told us deliveries were taking place in triage on a regular basis and were recorded in the birth centre register. We requested data and the trust told us that two women delivered in triage in 2015 and no woman have delivered in triage in 2016.
- The trust informed us that the use of the four bedded 'Blue Bay' on triage was within their escalation policy for an area to be used in times of reduce bad capacity. If

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this area was used, additional bank or agency staff were employed to man it. This area has been used once between January 2016 to August 2016 for three women who were either discharged or transferred back to the ward the following day.

- Patients reported to their community midwives that they were made to feel an inconvenience when attending the triage and they waited for long periods of time. One patient reported that she had been moved from the postnatal ward to triage blue bay (used for induction of labour) in the night and was 'ignored'.
- Staff were not aware of audit of the activity in triage despite the increase in the number of midwives required on each shift to cover the workload.
- The transitional care bay on the postnatal ward was closed at the time of our inspection. Recent changes to NICE guidance meant that babies receiving antibiotics for the treatment of infection were required to have longer hospital stays in order for them to be observed. The trust informed us following the inspection that the transitional care unit has not been formally opened since it was built. The trust also told us this unit was only opened during times of escalation and appropriately staffed.
- The postnatal transfer lounge was open between 7.45 am and 9.15pm. Between 15 and 20 patients were discharged daily. Women due to go home vacated beds on the postnatal ward and went to the transfer lounge for their baby to be checked and care records to be completed. This meant that beds were available on the ward for newly delivered patients. NMUH introduced daily NIPE clinics into the postnatal transfer lounge; two midwives were on duty each day to undertake NIPE. Women who had gone home before 72 hours could have their babies examined at home.
- At the weekends, the postnatal clinic was run in the outpatient department which meant women had a choice to attend a specific appointment rather than waiting in for a midwife to visit them at home.
- Between April 2015 and March 2015, bed occupancy for maternity was between 75% and 95% which was worse than the England average 60%. This might indicate that women had longer stays in hospital in comparison to the other trusts.
- Patients requiring the inpatient gynaecology service were cared for by nurses in a general surgical ward. One side room was used for patients undergoing miscarriage or termination of pregnancy. However, the bed allocation was not protected.
- Women that had problems in the early stages of pregnancy were assessed and reviewed in the Early Pregnancy Assessment Unit (EPAU) or Emergency Gynaecology Unit (EGU). Between the hours of 8pm and 8am they would be assessed and cared for in the Accident and Emergency department. From either department they could then be admitted to the female surgical ward to be reviewed regularly by the obstetric or gynaecology medical staff. We were told that a side room was used for patients experiencing a miscarriage, however this could not always be guaranteed.
- EPAU is opened seven days a week and offered appointments between 8am and 8pm. Referrals for investigation and treatment into bleeding in early pregnancy were accepted from midwives, GPs, nurse practitioners and the emergency department. There was access to scanning facilities each day and a medical opinion was available from the on call registrar or consultant who were supported by junior doctors. The EGU was open between 9am and 5pm each weekday.
- A side room was used on the general surgical ward specifically for women undergoing medical termination of pregnancy. We saw documentary evidence of one patient who was experiencing a miscarriage during the night admitted to the surgical assessment unit because there was not a side room available on S2.
- There was not an ambulatory hyperemesis gravidarum service. At the time of our announced inspection, five patients suffering from hyperemesis gravidarum attended accident and emergency who could not be treated in maternity due to lack of beds. This was on the risk register. A pilot hyperemesis at home service started on 1 July 2016 and was due for review in August and there were plans to have ambulatory hyperemesis service from November 2016. A brief review of the three patients that had used the service was carried out by the lead consultant for the pilot in August 2016. The managing director was named as the lead for the ambulatory hyperemesis project on the risk register and the completion date was anticipated as being November 2016.

Access and flow: Gynaecology

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- During our inspection we asked if patients using the inpatient gynaecology service were being cared for in other wards within the hospital and were told this was monitored by the site service managers as part of the bed capacity monitoring. There were no gynaecology patients on other wards during our visit.
- Compliance with two week waiting time for suspected cancer referral was 95.8% .
- The trust provided us with gynaecology referral to treatment (RTT) data for August 2016. The figure for 'incomplete pathways' (patients still waiting at the end of the month who were within the 18 week target waiting time) showed that 98.6% of patients were seen within the 18 weeks target. This was better than the England average of 90.9%. The information provided by the trust also showed that this figure was the third highest performance in the trust for the incomplete pathways. The trust also provided information for 'non-admitted pathways' which are waiting times for patients whose treatment started during the month and did not involve admission to hospital. This showed that 99% of patients under the non-admitted pathways were seen within the 18 week target and this was second best performance in the trust for this period. Data for 'admitted pathways' (waiting times for patients whose treatment started during the month and involved admission to hospital) showed that 90.9% were seen within 18 weeks.
- Colposcopy and hysteroscopy was offered on an outpatient basis.

Meeting people's individual needs

- Women with complex requests or needs, for example requesting home birth when risk factors were present, held discussions with the supervisor of midwives and a plan was then developed.
- The service ran specialist clinics to support women throughout pregnancy. For example, pre-existing medical conditions, perinatal mental health needs and fetal medicine.
- Specialist midwives for screening, diabetes, infant feeding and safeguarding who, had successfully completed additional training, gave advice and support to women and midwives.
- We saw that there were effective processes for screening for fetal abnormality. Women identified with a high risk of fetal abnormality, such as Down's syndrome, were invited into the clinic for on-going treatment and referral to specialist centres if appropriate.
- The trust offered parent education classes at the hospital and in locations in the community. In addition, two breastfeeding workshops were provided each week in the hospital.
- A designated consultant was responsible for perinatal health and ran a clinic for women with mental health needs. The Lavender Team in the community supported women with mental health needs in collaboration with the safeguarding midwife.
- Partners could visit between 11am and 8pm, and other people could visit between 6pm and 8pm. Partners could stay overnight in reclining chairs at the bedside.
- For gynaecology, visiting hours were 2pm until 8pm.
- We saw a variety of patient information leaflets available.
- We saw that there was an interpreter service available face to face or by telephone. Face to face interpretation was provided by Turkish link workers. We observed a patient in the gynaecology outpatient clinic using a face to face interpreter. Staff spoke positively about the availability of link workers to help understanding of people from Turkey.
- A variety of parent education classes were offered including preparation for birth and infant feeding. We saw that the trust had introduced a 10 week parenting group for parents with children from universal to complex needs and aged 0-18 years based on the Solihull Approach model of containment, reciprocity and behaviour management and uses social learning theory in the design of the parenting.
- We observed it took over 10 minutes for staff to respond to call bells on the maternity ward during our visit. Patients we spoke with also reported waiting for call bells to be answered.
- There were arrangements in place to support women and babies with additional care needs and to refer them to specialist services. For example, there was an on-site neonatal intensive care unit.

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- The consultant midwife ran a 'Birth Reflections' clinic in collaboration with the supervisors of midwives for patients who needed to discuss their birth and needed to debrief.
- There was a dedicated bereavement suite in the delivery suite. Parents who had experienced pregnancy loss over 16 weeks were cared for in this designated area. However, this was accessed via the labour ward despite having a separate entrance. Staff told us that this was due to a lack of security for the entrance local to the bereavement suite. Women experiencing pregnancy loss under 16 weeks were cared for in the EGU or inpatient services, we saw there was only one side room and no other dedicated facility for them which meant they may not always be cared for in a private area,
- A bereavement midwife saw all patients who experienced pregnancy loss, and undertook home visits if required. There was a nurse identified as a bereavement champion on the surgical ward where women experiencing pregnancy loss before 16 weeks were cared for. The nurse provided us with evidence that women were offered a choice about whether they wished to see the pregnancy remains, and also demonstrated where options for funeral arrangements were discussed.
- A cold cot was available on the bereavement suite which meant that babies could stay longer with parents. Memory boxes were available for all parents who experienced pregnancy loss.
- The bereavement midwife was trained to obtain consent for post-mortem. The trust had recently held its first multi faith memorial service for parents and families who lost a baby through miscarriage or stillbirth.
- SoMs were available to help midwives provide safe care of the mother, baby and her family. SoMs are experienced midwives with additional training and education which enabled them to help midwives provide the best quality midwifery care. They made sure that the care received met women's needs.
- The hospital had a varied menu and catered to a wide range of nutritional and cultural needs. Food was available outside of set meal times for patients in maternity if they could not eat at set meal times due to tending to their babies.

Learning from complaints and concerns

- Complaints and concerns were handled in line with trust policy. If a woman or relative wanted to make informal complaints, they would be directed to the midwife or nurse in charge. Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns. Patients would be advised to make a formal complaint if their concerns were not resolved.
- Information from the trust indicated that there were 63 formal complaints for maternity and 31 formal complaints for gynaecology between September 2015 and September 2016. Six informal complaints for maternity and one informal complaint for gynaecology were made between in the same time frame. Four cases of litigation were opened in the last 12 months.
- We saw an information leaflet for patients and those close to them informing them of how to raise concerns or make complaints. Once a complaint was made, it was forwarded to the trust complaints team where it was prioritised and distributed to responsible officers for investigation and response within 30 working days.
- There were 11 open complaints at the time of our inspection; four were overdue, three were due and four were new. Overdue complaints were monitored and were awaiting the outcome of investigations.
- We discussed learning from complaints and concerns with the management team who told us that the capacity of the Birth Reflections clinic has been increased from monthly to fortnightly in response to complaints

Are maternity and gynaecology services well-led?

Inadequate 

We rated well led as inadequate because:

- The leadership, governance and culture did not always support the delivery of high quality person centred care.
- Leaders did not have the necessary experience, knowledge, capacity, capability to lead effectively.

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- Staff had no clear vision and strategy of the maternity and gynaecology service. Staff could not tell us of future plans for the maternity service; however outpatient gynaecology staff described the relocation of their services to more suitable accommodation.
- The culture was not one of fairness, openness, transparency, honesty, challenge and candour. Several staff reported bullying, harassment and discrimination amongst staff at all levels, in the maternity unit. When staff raised concerns they felt they were not treated with respect.
- The culture was defensive with poor collaboration between the staff working in different departments. High levels of conflict were reported to us.
- Leaders were not always described as visible and approachable in maternity; however they were visible in the gynaecology service.

However:

- Guidelines we reviewed were in date, reflected current NICE guidance and best practice, and included evidence of learning from SI reviews.
- The trust participated in the North Central London Maternity Services Liaison Committee (MSLC), a specialist user involvement forum which brought together users and health professionals to develop women-centred maternity services.

Vision and strategy for this service

- A three year strategic vision had been developed that supported NMUH's key strategic objectives and aimed to ensure services met CQC standards of safe, caring, effective, responsive and well-led services. The HoM told us that the strategic vision focused on clinical services, workforce and service users. A one year business plan supported the vision and had been designed to match CQC domains.
- The maternity service vision included: to be the provider of choice to both the local population and to new areas; supporting the National Maternity Review's vision for the future of maternity care; increasing the number of deliveries to ensure the unit is viable; providing a seamless pathway of care that places the woman at the

heart of care; ensuring more women deliver in the midwifery-led service through new models of care; and the introduction of new technology and new ways of working to support 21st Century care.

- For gynaecology the vision included being recognised as a provider of excellent secondary care outpatient, diagnostic, non-elective and elective gynaecology services that complements primary care provision; the provision of responsive services that grasp new technology that promotes improved outcomes for women; and the recognition as a centre of excellence for uro-gynaecology and endometriosis care.
- The business plan identified a range of key priorities for the maternity and outpatient gynaecology services to support the vision.
- We saw documentary evidence that the NMUH Board wanted to increase the number of babies delivered (activity) in the unit and was disappointed that this had not yet been achieved.
- Staff we spoke with could not describe the vision and strategy for the service. Community midwives were aware of the plans to expand the catchment area as they were already working in areas beyond the M25 boundary.

Governance and risk management

- A revised clinical governance structure was in place following the recent appointment of the new chief executive. The HoM told us that the NMUH received external support from management consultants.
- Obstetrics and outpatient gynaecology was part of the Clinical Business Unit 5. Gynaecology inpatients were cared for on a surgical ward which was managed by Central Business Unit 4. Staff told us there was no clear pathway of communication between the two business units to ensure a coordinated approach to the care of gynaecology inpatients.
- Leaders were unclear about their roles and accountability in relation to the gynaecology service. For example, the staff including senior managers, the HoM and a consultant obstetrician could not describe the process for auditing the completion of the documentation required under the Abortion Act 1967 and Abortion Regulations 1991?

Maternity and gynaecology

- A risk coordinator managed obstetrics and gynaecology risk. Incident submissions were reviewed daily. Managers met at a weekly maternity risk meetings and fortnightly gynaecology risk meetings to review incidents. Risk meetings reported to the monthly CBU Obstetrics and Gynaecology Clinical Governance Coordination Meeting which in turn reported to the quarterly Maternity Board and CBU5 Management Meeting, both of which fed into a more senior trust meeting which was responsible to the Board.
- All staff were invited to a weekly risk meeting, however due to the capacity of the clinical areas, they did not attend. Junior doctors did attend.
- We were told that following review at the weekly meeting, significant incidents such as intrapartum stillbirth were subject to a multidisciplinary rapid review within 24 hours. The risk coordinator coordinated reports which were reviewed by the senior management team who decided whether the threshold for reporting to STEIS and commissioners was met and allocated the case to a lead investigator.
- A monthly Perinatal Mortality and Morbidity Meeting reviewed adverse events in order to identify the causes so that steps could be taken to prevent recurrence. We saw between January and March 2016 a review summary in which themes, key actions and learning points for the maternity service and wider trust were documented. An action plan was not provided; we were not assured actions were completed. For example, one action was 'GROW project implementation to identify the IUGR cases' which had not been implemented by the time of our inspection. This meant that babies at risk of poor fetal growth were not being detected to allow timely intervention.
- A report on stillbirth was submitted to the trust board in May 2016 (Report into antepartum stillbirth 1/1/12 – 31/12/2015) that made several recommendations. Most of these recommendations had not been implemented at the time of our inspection.
- The Antenatal Screening Committee met quarterly. A labour ward forum met monthly to identify areas of good practice and new evidence based guidelines
- The Audit and Guideline Committee met monthly. We reviewed five guidelines that we selected randomly. We saw all were in date, reflected current NICE guidance and best practice, and included evidence of learning from SI reviews.
- The Managing Director was responsible for the maternity and gynaecology risk register, which contained 18 risks for September 2016; 14 related to maternity and three related to gynaecology. A further risk related to the fertility service, which is not part of this report.
- The Trust does not use RAG rating for its risk registers as all risks are scored to indicate the level and impact of risks. We saw that action logs which contained actions, agreed responsibilities and a column for timelines were not consistently completed. Risks we expected to see, for example midwifery staffing, were not included on the risk register. However, 12 SIs were listed on the risk register. We asked senior staff about this and were told that this is how the trust monitors activity and progress against SIs.
- The RCOG Good Practice No. 7 (Maternity Dashboard: Clinical Performance and Governance Score Card) recommends the use of a maternity dashboard. The maternity dashboard serves as a clinical performance and governance score card to monitor the implementation of the principles of clinical governance in a maternity service. This may help to identify patient safety issues in advance so that timely and appropriate action can be instituted to ensure woman-centred, high-quality and safe maternity care.
- The dashboard was displayed in clinical areas. The service had introduced the North Central London (NCL) Maternity Network. The interface with the CCG enabled benchmarking against other London trusts and nationally. NCL were reviewing the dashboard alongside the RCOG dashboard to ensure all outcomes were measured. For example the NCL dashboard does not record VTE scores.
- A daily safety huddle took place on the delivery suite where safety alerts and lessons learned from incidents were shared. We observed one safety huddle, led by the consultant obstetrician, in which the need to record omission of medicines was discussed. The safety huddle did not include an overview of staffing or capacity.

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- Staff told us that they received feedback in various ways. Performance issues were taken up with the individual staff member. We were told a quality and risk newsletter 'Burning Issues' was available electronically and in hardcopy, however we could not locate a copy of the newsletter on our inspection.

Leadership of service

- The women's services was led by the Head of Midwifery, the managing director, the clinical director for CBU5 and the deputy clinical director for obstetrics and gynaecology. We were told that there had been three substantive heads of midwifery in six years; staff we spoke with expressed concern at this lack of stability.
- Leaders did not have the essential experience, knowledge, capacity or capability to lead effectively. There had been three substantive heads of midwifery in six years. We were not assured that the cause for this had been explored and solutions identified to support the current HoM.
- Leaders were not always visible and approachable; seven out of 23 midwifery staff spoke negatively of matrons within their departments and their support in general. Staff said that senior managers were not visible.
- Initiatives were sometimes introduced without involvement of the staff. For example the Maternity Triage form had been developed and introduced shortly before our inspection without consulting staff.
- We were told that the HOM had direct access to the trust board. This meant midwifery issues were taken to the board by staff with oversight and understanding of maternity service issues.
- We spoke with a non-executive director (NED) of the board who told us of the board's concerns about the operational and financial management of the maternity service and its reputation locally: "I go to a website where patients complain directly – maternity features often. I check FFT and it is negative". The NED told us that "Not everyone points at the same direction" and "We have magnificent facilities, it should be happy time".

Culture within the service

- The culture was not one of fairness, openness, transparency, honesty, challenge and candour. Staff we spoke with in the maternity service gave us examples of

bullying, harassment and discrimination amongst the staff, at all levels. High levels of conflict were reported to us between certain groups of staff and staff were anxious about being seen speaking with us. We were not assured that the culture was being managed effectively.

- We were not assured that relationships in maternity were protecting patient safety. We were told that transfer from triage or the birth centre was sometimes problematic, depending on who the labour ward coordinator was because of poor relationships between staff members. The effect of this was that patients were not always transferred in a timely manner putting them at risk of not receiving the treatment and care they required.
- Evidence of perceived bullying on the labour ward involving student and preceptorship midwives was provided to us. When asked about this, senior managers told us an investigation was ongoing and appropriate action would be taken dependant on the outcome. Nine members of staff told us directly they had experienced poor behaviour towards them on the labour ward and one 'witnessed staff being reduced to tears at times'.
- One midwife told us she had "lost the confidence I'd work so hard to get" when working on labour ward; another told us "it depends on who is the coordinator as to whether you have a good shift or not"; another told us she asked to be moved or "I would have had a nervous breakdown". Community midwives reported poor support when they were sent to the delivery suite to work as part of the escalation policy.
- Staff and patients told us of incidents of racism. Some staff told us they felt victimised for being from a different racial background. A number of patients told us that they felt their concerns were not listened to because they were considered 'white middle class'.
- When asked, the labour ward matron described staff as "challenging characters" but denied there was a bullying culture. We witnessed poor interaction between medical staff and the labour ward coordinator who was abrupt and rude when challenged about the care of patients in high dependency and left the room without resolving the issue.
- Staff told us when they raised concerns they felt listened to but did not feel any action would be taken. For

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example, bullying behaviour by a manager was drawn to the attention of the HoM but the staff member did not receive any response. Another midwife who reported poor attitude from a colleague midwife was told by her manager that she must “wait until she (the colleague) retires” and work with her until then. Other staff told us that if a problem was identified, the staff member was moved; “they move the problem rather than deal with it”.

- Staff in triage and the birth centre told us they did not raise concerns with some managers due to the poor communication of the matron and poor working relationships.
- When staff raised concerns they were not always treated with respect. One member of staff told us that a manager said “you are insignificant”; this was related to the fact that the staff member was part time.
- Staff told us the culture was defensive with poor collaboration between the departmental areas and wards. The HoM told us that “Staff are friendly although they do tend to work in silo”.
- Agency staff were employed to cover shortfalls in preference to substantive staff. When substantive staff asked to increase their hours, this was denied despite an ongoing vacancy factor. However, the trust told us that all staff who requested to increase their hours are considered on a case by case basis. The decisions in two recent cases where increases in hours were not approved were taken after consideration of sickness records, patient complaints and the fact that additional hours were requested at a higher band than was available within budget.
- We were made aware of a staff grievance that had not been addressed since it was submitted three months ago. However, the trust informed us following the inspection that the grievance was processed in accordance with the trust policy and which was not upheld at a hearing in July 2016. An appeal has since been made subsequently.
- Staff told us they regularly worked long shifts without a break.
- Staff on the maternity ward told us that some staff can be very disrespectful and ‘talk to you in not a very nice way, you know who they are and keep out of their way’.

- Junior doctors reported that the consultants were supportive, friendly and approachable’ and there was ‘unity amongst colleagues’. However, they also told us some midwives were ‘aggressive and undermine the trainees’.
- Administrative staff reported a bullying culture in which some staff were promoted above their level of ability due to favouritism; they were concerned that they were undertaking the same work for a lower rate of pay as colleagues elsewhere in the hospital.
- However, some staff reported good support from senior managers.

Public and staff engagement

- The NCL Maternity Services Liaison Committee (MSLC) was a specialist user involvement forum, which brought together users and health professionals in the area, to develop women-centred maternity services which are appropriate, acceptable and accessible to the local population. The MSLC was accountable jointly to NCL Maternity Board. All maternity services in NCL held three to four local user forums to seek the views of service users. The NMUH held quarterly structured focus groups.
- We saw the minutes for focus groups held in February 2016 and May 2016. Ten women participated in February 2016 and 15 in May 2016. Overall, patients were satisfied with their care and staff at the NMUH and all (100%) of them would recommend maternity services to their friends and family. Action plans were included in the minutes to address areas where patients had identified issues such as staff behaviour in triage and ensuring skin to skin contact time is given at caesarean section and patients were shown how to breast feed. A responsible person and time frame was listed, however progress on actions were not followed up or completed.
- The HoM reported to the board ‘maternity unit does not currently undertake any formalised local staff feedback or surveys, but anecdotally there is an ongoing issue with staff being too busy and being unable to take their breaks. The unit is looking to sign up to the RCM campaign for healthy workplaces, which aims to support staff in maternity units across the country’.

Innovation, improvement and sustainability

Maternity and gynaecology

- A Direct Maternity Line had been introduced following the 2015 CQC patient survey. This meant that between 9am and 6pm, patients could phone a dedicated telephone number to seek advice from a midwife.

Services for children and young people

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

Information about the service

Children's services within the trust consists of a neonatal unit which has 22 cots with two cots designated for intensive care (ITU) and four as high dependency (HDU), and Rainbow Ward with 25 beds including two ITU and up to six HDU spaces. Additionally the Starlight short stay unit has 12 beds including a 3-bedded bay as a surgical day unit, and the Paediatric Assessment Unit (PAU) has 4 bed spaces with a waiting area. The Paediatric Day Assessment Unit (PDAU) has four beds for the treatment of children with conditions such as sickle cell disease and an outpatient unit with a variety of clinics including allergy, asthma, cardiology, dermatology, diabetes, endocrine, epilepsy, gastroenterology, haematology-oncology, HIV, renal, respiratory and rheumatology.

The service has a paediatric community team with six paediatric community children's nurses.

The service also has links to a nearby charitable hospice which provides care for children with life limiting or life-threatening conditions.

Between the 1 March 2015 and 29 February 2016 children's services treated 11,115 patients.

During the inspection we spoke with 20 parents/guardians, five children and 44 members of staff including nurses, doctors and other health professionals. We visited the neonatal unit, rainbow ward, starlight short stay ward, the PAU, the PDAU as well as the children's outpatients department and the theatre.

Summary of findings

We rated this service as requires improvement because:

- The service had a lack of ownership or oversight of children being cared for in other areas within the trust where the care environment was substandard and the service did not have oversight of young people over the age of 16 years who were cared for in adult clinical areas of the trust.
- Although some young people in transition had been consulted on their transition to adult services, audits to fully capture the voices of children and young people had not been undertaken.
- There were some ongoing issues with staffing levels and only 56% of the nurses in the neonatal unit were qualified in that specialty.
- There was poor oversight of patients with learning disabilities who were not identified on admission.

However:

- This service provided generally good care to children and babies within good standards of accommodation where the environment in which children were cared for was reflective of their needs.
- The service had effective systems to identify children who might deteriorate whilst receiving care and used

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the recently introduced Royal College of Paediatrics and Child health SAFE Programme based on work undertaken at the Cincinnati Children's Hospital in the USA.

- There was a good level of safeguarding awareness among staff we spoke with.
- We saw that there was excellent multidisciplinary team (MDT) working and clinical teams worked collaboratively to enhance the provision of care to children. Parents told us that they were fully involved in the care delivered to their children and that health care professionals kept them informed at all times as to the progress of their individual children.

Are services for children and young people safe?

Good



We rated safe as good because:

- The full utilisation of the RCPCH SAFE programme and the use of the MIDSEY huddles optimised patient safety and the early detection of deteriorating patients.
- Staff demonstrated an open and transparent culture about incident reporting and there was a strong culture of safeguarding patient safety amongst nursing, allied health care professionals and medical staff. Staff understood their roles and responsibilities in reporting incidents and described how they learnt from incidents.
- Patients were safeguarded from the risk of abuse through robust safeguarding policies. All staff we spoke with were familiar with these policies and were able to describe the action they would take if they thought a child was at risk of abuse or neglect.
- Standards of infection prevention and control were mostly good throughout the service.
- There was consistent and effective use of patient early warning tools.

However:

- Young people over the age of 16 years were cared for in adult services with no oversight from children's services and as a "you're welcome" audit had not been undertaken it could not be determined if the trust was young person friendly and therefore sensitive to the safety needs of young people as patients.
- We could not be assured that medications were always stored safely as some drug fridges were recorded as having frequent temperature regulation breaches potentially affecting the safe storage of patient medication.
- A resuscitation grab bag was missing vital equipment and there was no difficult airway box on the neonatal unit.
- The number of staff without advanced paediatric life support (APLS) and paediatric immediate life support (PILS) training put children at risk in the event of an emergency requiring timely resuscitation.

Services for children and young people

- Only 56% of neonatal nurses were trained in speciality as opposed to the 70% recommended by the British Association of Perinatal Medicine.

Incidents

- Between August 2015 and July 2016 there was only one serious incident (SI) reported by the trust related to services for children and young people. There were no never events reported. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. The SI occurred in April 2016 and related to abuse/alleged abuse of a baby by a third party.
- Between July 2015 and June 2016, the trust reported 58 incidents to the national reporting and learning system (NRLS) which related to services for children and young people. Of these 46 were no harm (potential harm that was prevented) and 12 were low harm (resulted in extra observation or minor treatment and caused minimal harm.) The most common incident category was "access, admission, transfer, discharge (including missing patient)". This accounted for over a fifth of incidents (12). This was followed by medication incidents and incidents related to consent, communication or confidentiality (five each). The majority of incidents were not reported to NRLS until 90 or more days after the incident occurred (64%). This level was in-line with the trust average.
- Data provided by the trust showed 417 incidents had been recorded for children and young people's services between July 2015 and June 2016. Of these incidents 341 were recorded as no harm and 73 low harm, two were moderate harm and one was severe harm where the incident resulted in permanent harm to the patient due to failure to report pathology results. The most common category recorded was records missing / unavailable (51) followed by staff shortage in a clinical area (36).
- There were no reported incidents via the safety thermometer between June 2015 and June 2016. The department held monthly mortality and morbidity (M&M) meetings to identify whether any patient deaths were preventable and whether there were any learning points to be shared from the case notes review. We asked the trust to provide the minutes of any M&M meetings from the six months prior to our inspection and we were told that generally, the meetings were not formally minuted and therefore they could only provide minutes of the July 2016 meeting. The trust told us that any meeting outcomes were instead recorded on a case note review spreadsheet. We were provided with a copy of this document covering May to July 2016. Although three deaths had been recorded no key actions or learning points had been identified. We were told by the trust that learning tended to be incorporated into training and education sessions. We reviewed the minutes of the July 2016 meeting. Although the minutes did include actions allocated to specific individuals these actions were not given timescales for completion. There was also no discussion of previous actions. We were told that only doctors attended the morbidity and mortality meetings.
- Incidents were discussed at the monthly staff meeting on the neonatal unit and we saw evidence of the weekly safety audits (August 2016). We saw that poor performance was being addressed and for example we saw that a pilot of new documentation was in progress to more accurately record the weight and feeding regime of babies.
- Patient safety and service quality (PSQ) meetings were held monthly where risks and actions were discussed. Information about incidents was cascaded to all staff via 'Burning issues' which was a paper newsletter focused on safety issues along with a "hotshots" email containing feedback from the PSQ meetings.
- We saw example where lessons learned from incidents had been cascaded and new procedures had been introduced as a result. For example new total parenteral nutrition guidelines had been produced and staff were now double checking expressed breast milk after an incident relating to labeling to ensure that it was correctly labelled and in date. Subsequently spot checks of the milk bank by one of the neonatal sisters had been introduced.
- Members of the senior management team told us that some serious incidents were recorded on the department's risk register to further highlight the importance of learning from these specific incidents to improve patient safety.

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- The staff we spoke with across children's services were fully aware of how to report incidents via the trust's electronic reporting system. The senior management team told us that all staff within children's services were encouraged to report incidents. Staff members told us that training in the use of the incident reporting system was part of the induction process. Student nurses we spoke with who were on placement within the children's services unit had also been made aware of the reporting system and had observed their mentors using the process. The electronic reporting system allowed staff at all levels to report adverse events and near misses and assisted initial recording through to investigation and subsequent root cause analysis.
- Safety meetings were held each morning at 8.30 am with attendance by the senior nurses from paediatrics and the neonatal unit. These meetings were used to discuss any incidents that had been reported by staff within the department and to identify any immediate actions needed.
- We saw evidence that the duty of candour was fully embedded and for all incidents the senior nurse, or a consultant, met and spoke with parents or guardians. Staff told us that they understood their responsibilities regarding the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. There were local arrangements in place for ensuring that patients and their carers were kept informed of incidents and were provided with the necessary support as well as being kept informed of any investigations and their outcomes.
- The clinical teams used the SAFE (Situation awareness for everyone) programme. North Middlesex Hospital had been one of 28 hospitals which had worked with the Royal College of Paediatrics and Child Health (RCPCH) in participating in a two year programme to develop and trial a suite of quality improvement techniques to improve communication, build a safety-based culture and deliver better outcomes for children and young people, known as SAFE. The SAFE programme was designed to reduce preventable deaths and error occurring in the UK's paediatric departments.
- We saw that the SAFE handover process was being used in each staff handover we attended and that structured communication was evident in the discussion of each child. This included handover discussion on staffing issues, regarding both nurses and doctors, bed occupancy status, and any ward concerns such as drug errors and other incidents during the previous shift, equipment failures or shortages, patients with intravenous lines or catheters or any high risk therapies as well as any other safety concerns raised by parents or staff. SAFE was primarily designed to help identify sick children who were in danger of medical deterioration. The SAFE handovers also discussed individual patients with PEWS scores greater than four. The paediatric early warning score (PEWS) was designed to help health care professionals to recognise 'at risk' children and to trigger early referral to medical staff, so that early intervention can be implemented to prevent deterioration.
- The consultants we spoke with across children's services were very proud of the SAFE initiative and positive impact that it had on patient care.
- Following the handovers staff engaged in a 'MIDSEY huddle'. The clinical huddle was developed to improve situational awareness with an emphasis on communication and is part of the SAFE programme. We saw that the huddles highlighted "at risk" patients and encouraged communication between the ward staff. Huddles were held twice daily and all incidents were discussed. The MIDSEY is an acronym for mothers concerns, increased risk the therapies, sick deteriorating patients, staff concerns, extra risks, your plan. This provided a structured framework for staff in assessing and identifying patients' risks.
- The MIDSEY huddles provided an opportunity for staff to develop confidence to speak up and jointly act on any safety concerns they had. These huddles had become a method for the clinical teams to continually learn and improve and we saw that it covered the acuity and dependency of each child. Additionally, staffing and capacity, end of life care and safeguarding issues were discussed.
- Data from the CQC's 2014 children's survey showed that the answer to the question "did you feel that your child was safe on the hospital ward" was worse than in other similar trusts. Despite this parents we spoke with did feel that their children were safe in hospital.

Services for children and young people

Cleanliness, infection control and hygiene

- There were link infection control nurses in each of the designated areas of children's services and the staff we spoke with knew the name of the infection prevention and control (IPC) lead nurse.
- We saw that there were regular IPC meetings which were held bimonthly and that IPC mandatory updating was 95% compliant. Staff were given time off to complete IPC training.
- We saw that infection control information was visible to both staff and visitors entering clinical areas. Hand washing sinks and hand sanitisers were available at the entrance to the clinical areas.
- We saw evidence of regular hand hygiene audits and inspected the audit completed in August 2016 which was 100% compliant and also saw that IPC information was cascaded to staff via the ward dashboards. We reviewed the results of the weekly hand hygiene audit for January 2015 to March 2016 and found that generally the trust target of 95% compliance was being met by staff for most months. However, compliance was not always consistent. Sunrise unit met the target in all months except March 2016 where they scored 87%, whilst starlight ward and the PDAU did not meet the target for six of the 15 months reviewed, with the lowest compliance in February 2015 where the ward only achieved 67% compliance.
- Cleaning protocols for each clinical area were available within the cleaning cupboards and cleaners we spoke with told us that they followed the protocols each day. The clinical areas had regular housekeeping cleaners and we saw that they were treated as part of the ward teams. The clinical areas were visibly clean and tidy and we observed the domestic staff at work in all parts of the service including the outpatient department undertaking cleaning duties. Cleaning was outsourced to a private company but the wards had regular cleaners who were familiar to the ward staff.
- We saw that the waste management met national guidelines and that national colour coding was in use for mop heads and other cleaning equipment.
- Sluices and dirty utility rooms were clean and tidy and items such as commodes were visibly labelled with "I am clean" stickers which were dated. We also inspected a range of patient equipment such as blood pressure cuffs and bedside tables and saw these were clean. We checked four of the incubators within the neonatal unit which were all clean and labelled with green "I am clean" stickers.
- We found that single use equipment such as purple syringes were available and were stored in an appropriate storage cupboard.
- Guidance was available to staff regarding the cleaning of patient equipment and protocols related to all aspects of infection control were available either in folders or via the trust intranet library of policies and procedures.
- The staff we spoke with told us that they thought the clinical areas were very clean and that the domestic staff did a good job and the parents we spoke with told us that they saw nurses and doctors washing their hands and wearing appropriate personal protective equipment (PPE). Parents commented on the cleanliness of the clinical areas. We saw that staff followed the 'bare below the elbows' policy and washing their hands or used hand sanitisers prior to any patient contact. We also saw parents and visitors using the sinks and hand sanitisers.
- We inspected a range of patient related infection control equipment and saw that two sharps boxes had not been dated or signed to confirm they had been safety checked by staff.
- We saw that one of the bays within the neonatal unit was used for equipment storage as the unit was only funded for 22 cots although 28 could be accommodated but were this to be the case there would have been no room for storage.
- The clinical areas were visibly clean and tidy including the nursery areas of the neonatal unit. Curtains within the neonatal unit were washed each month by the housekeeper.
- All toys were cleaned regularly on a weekly basis and daily as required and we saw the toy cleaning schedule was fully completed and dated and signed.
- During our inspection there were no outbreaks of either MRSA or Clostridium difficile, which are both infections that can occur in a hospital environment.
- Data from the 2014 Children's survey showed the answer to the question "how clean do you think the hospital room or ward was that your child was in?" was worse than in other similar trusts. However, none of the parents or carers we spoke with raised any concerns about cleanliness.

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Environment and equipment

- Children's services consisted of a neonatal unit which has 22 cots with two cots designated for ITU and four as HDU, and Rainbow Ward with 25 beds including two (and up to six) HDU spaces. Additionally, the Starlight short stay unit had nine beds, and Paediatric Assessment Unit (PAU) with 12 spaces and an adjacent three bedded surgical day unit.
- The Paediatric Day Assessment Unit (PDAU) had four beds for the treatment of children with conditions such as sickle cell disease, and the adjacent outpatient department held a variety of outpatient clinics. Including among other allergy, asthma and cardiology.
- The neonatal unit had four dedicated parent rooms and was level 2 UNICEF accredited and was BAPM compliant.
- Each of the clinical areas where children were inpatients were locked, preventing unauthorised access and monitored by CCTV. Parents/carers and visitors were able to gain access to the clinical areas by using a buzzer system, which was monitored by nursing staff. We saw that members of staff greeted each visitor as they entered each of the clinical areas. We did not see information about tailgating.
- We checked all of the resuscitation trolleys throughout the service and each clinical area had resuscitation equipment with emergency drugs, oxygen and echocardiogram machine. Daily checks were documented in every area we visited. We saw that there was no difficult airway box on the neonatal unit and this potentially could have compromised resuscitation attempts.
- The resuscitation grab bag we inspected was not fit for purpose as it did not contain an ambu resuscitation bag and the bag had not been signed for intactness on a daily basis although there was an adjacent chart to do so. The ambu bag is a manual resuscitator or "self-inflating bag", it is a hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing.
- We examined a range of equipment within children's services including breastfeeding equipment, the breast milk fridge, and the medicine fridges and all were clean, labelled and dated.
- We found temperature monitoring on the drug fridges had not been completed and there was no guidelines for staff on how to escalate temperature variations.
- The fridge for storing expressed breast milk (EBM) was checked daily and was compliant to national recommendations which states that the temperature of a refrigerator storing breast milk should be maintained at 2-4°C.
- We visited the eye clinic within the general outpatients department to assess its suitability for children and found it did not comply with national recommendations. This service held a specific child clinic on a Monday morning but also hosted a child emergency clinic every day. The waiting area was for both adults and children. We only saw two plastic toys, both of which did not appear to have been recently cleaned and there was no child-friendly decor in the waiting areas. The nurse we spoke with did not feel that there were any issues and told us that they did not bother with toys as they had all been stolen previously. The children attending this clinic were triaged in a generic triage room devoid of child friendly ambiance. No paediatric nurses or any nurse with a paediatric background were employed by this service. All staff were level 1 or 2 safeguarding trained but only the manager was level 3 trained. There was no play specialist input and no liaison with children and young people's services.
- We also inspected the fracture clinic where children were seen but which was not part of children's services. There was no oversight of these adult areas by members of children's services. There was a small children's waiting area which was shared with the clinic next to fractures. We visited this and found it poorly lit and unsupervised, it was placed in a corner out of the eye-line of reception staff. The only toys were a couple of books. The area looked un-cared for and unused. The nurse we talked to in the fracture clinic told us it was rarely used and instead children used the main adults waiting area. Sometimes children were left alone if their parent went to get treated and the lead nurse for the unit said they were happy with this as long as they let reception staff know. However, they were usually left unattended near the TV which was at the furthest end of the waiting area from reception and therefore it would be almost impossible for reception staff to see the child.

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It was also right next to the open doors leading to the next clinic. At the time of our visit there were no children using the clinic waiting area but we were told by staff that they did get several children each day.

- Children's services had a range of equipment that was cleaned and checked regularly and was sent for routine maintenance. Staff were aware of whom to contact or alert if they identified faulty equipment or environmental issues that needed attention. We checked multiple items of equipment in the neonatal unit which had all been recently safety tested.

Medicines

- We visited the treatment rooms, storage rooms and medicine preparation areas across the service and all were clean and tidy, with no medicines seen lying around unnecessarily.
- The drugs trolley on the neonatal unit was kept locked and although there was no hard copy neonatal formulary one of the neonatal sisters had made a neonatal medicines book which she had reviewed and updated every six months.
- The drug trolley on Rainbow ward was kept in a key locked room but when we examined the log sheets we noted that there had been inconsistent checking of the trolley contents by staff.
- A registered nurse was responsible for the keys to the drug cupboards and lockers.
- The paediatric pharmacist visited the neonatal unit daily to check among others the expiry dates of total parenteral nutrition preparations. Children's services had a dedicated pharmacist available Monday to Friday between 9am and 5pm with on call facilities at other times. The nursing and medical staff told us they were happy with the pharmacy service received out of hours during evenings and weekends. They all told us that the support and advice they received from their paediatric pharmacist was good.
- Controlled drugs were kept in a locked cupboard within the neonatal unit and we inspected the drugs and the controlled drug log book and found all procedures were in place to safeguard them. Checks were undertaken by

staff twice daily and controlled drugs were correctly documented in a register, which was in line with National Institute of Health and Care Excellence (NICE) guidelines.

- The National Paediatric IV Administration Guide (Medusa) was used by the pharmacists. Medusa is a website which contains monographs (printable information leaflets) on the administration of injectable drugs.
- Medicine lockers to dispense patient's own drugs (PODs) were in place and parents could be empowered under the control of a nurse to use these. POD schemes involve patients bringing supplies of their own medication into hospital so that, following assessment by pharmacy or nursing staff, they can be used during their inpatient stay and/or at discharge.
- We reviewed four drug charts and saw that all the children's details were appropriately recorded, with the child's weight and allergy status documented. We saw that medications had been prescribed by registered medical practitioners and each chart was found to be legible.
- The drug fridge temperature monitoring was poor and some drug refrigerators were noted to have had frequent temperature regulation breaches potentially impacting on the optimum storage of patient medication. Although a replacement fridge had been ordered it had not appeared and was assumed lost.

Records

- We saw that there were systems to flag on records where a child had particular needs including child protection and this was widely understood.
- We saw that patient's paper records were stored very securely in lockable cabinets.
- We looked at nine sets of records on Rainbow ward and noted that in three cases that PEWs charts had not been completed and escalations not recorded. We examined three sets of records on the neonatal unit which were fully completed.
- In the records we saw that each child had a plan of care and babies on the neonatal unit had breastfeeding plans in line with UNICEF baby friendly guidelines. The neonatal service at the trust had achieved level 2 UNICEF Baby Friendly Initiative accreditation.

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- We also noted as appropriate that the patient records we reviewed contained up to date pain assessment charts.
- Nurses received clinical documentation training as part of their induction and ongoing mandatory training. However, we saw that Information governance mandatory training rate was 81.7% vs trust's target of 90%.
- There was evidence of input from the multidisciplinary team, and the names and grades of staff contributing to the records were clearly documented.
- Fluid charts and prescription charts had all been clearly and accurately completed.
- Staff we spoke with in the outpatient departments told us that records arrived in the outpatients in a timely fashion.

Safeguarding

- The trust's children's safeguarding team was formed of three named leads for safeguarding and their deputies. The team was responsible for providing all safeguarding children training at the trust.
- We saw that gang-related violence and female genital mutilation (FGM) projects had been well managed and that staff we spoke with were fully aware of these safeguarding issues.
- The maternity service had introduced a substance misuse clinic for pregnant women designed to provide antenatal support prior to a baby being born.
- We were told of an ongoing safeguarding project which was initiated to target child sexual exploitation. The safeguarding team had produced a resource pack which was given out to children 12 and over in the emergency department. The information pack was placed in white bags to avoid being linked to specific gang colours. Feedback from community youth groups had been positive. Funded via multi-agency donations the resource packs included information on sexual health, mental health, LGBT, and domestic abuse.
- The trust's child protection policy (issued April 2016) clearly stated which staff required which level of safeguarding training. All staff working in health-care settings were required to complete level 1 training. All non-clinical and clinical staff that had any contact with children, young people, and/or parents/carers were required to have level 2 training. Level 3 training was only required for staff who could potentially contribute to assessing, planning, intervening, and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
- Data provided by the trust prior to the inspection showed that staff within the paediatric department did not always have the correct level of safeguarding training. However all the staff we spoke with were able to tell us the correct procedures to be followed when suspecting abuse in either children or adults. For example the play leader told us that she had a good relationship with the safeguarding team and that she had been updated with level 3 training and that she was given time off to complete the safeguarding e learning modules.
- Staff had quick access to safeguarding team and each staff member had been given a contact card with the safeguarding team phone numbers. Although there were no specific safeguarding leads at ward level the named leads attended the clinical areas daily to identify new referrals to the service. In situations where the safeguarding leads were off site they telephoned the ward managers every day to check for new referrals.
- There was a high level of awareness about safeguarding among all grades of staff and weekly MDT meetings were held to review all referrals to child protection.
- The medical staff had published a paper entitled "12 years on from the Laming Report from recommendation to practice" in which they conducted six audits of the 27 Laming recommendations. The results of these audits had shown that significant improvements in child protection documentation within children's services had taken place.
- Although 100% of staff on both sunrise unit and rainbow ward had completed safeguarding children level 1 training, only 87.5% of children's admin staff had completed the training. This meant that overall 86.4% of staff had completed level 1 training which did not meet the trust target of 90%. Certain paediatric staff groups such as frontline nurses were required to undertake level 2 or 3 safeguarding children training. Of those staff required to complete level 2 training 69.2% had done so. Of staff required to complete level 3 training 85.9% had done so. Rainbow ward and sunrise unit both met the

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90% target with 93.3% and 91.9% of staff who were required to have completed safeguarding children level 3 having done so. However, only 72.7% of paediatric medical staff had completed the training.

- Of relevant staff within the paediatric department 88.9% had completed safeguarding adults level 1 training and 56.7% had completed the level 2 training. Rainbow ward had the lowest compliance rate with only 42.9% of staff having completed level 2 training, followed by sunrise neonatal unit where 44.4% of staff had completed the training. This did not meet the trust's target of 90%.
- Nurses told us that trust security guards were sometimes slow in responding to patient incidents on the wards e.g. where an adolescent was behaving aggressively towards staff members. However, in the case of children with anger management issues or mental health conditions restraint was avoided until the help of a specialist mental health nurse (RMN) was obtained. Staff told us that it was sometimes difficult to get RMN's for children who were identified as needing one to one for example for children who had self-harmed.
- The trust had developed an abduction policy as a response to two previous abductions from the maternity unit two years earlier. Although both babies were later recovered this had prompted a review of trust policy and served to raise awareness of security and the staff's powers to detain. The lessons learned from this event had led to changes and some but not all staff felt well prepared for such an eventuality. This was because some staff we spoke with were not aware of the existence of the abduction policy. We saw that staff had quick access to members of the safeguarding team and each staff member had a contact card with team telephone contact numbers.

Mandatory training

- Data provided by the trust prior to the inspection showed that the percentage of paediatric staff who had completed mandatory training as at 16 August 2016 was 79.5%, which did not meet the trust target of 90%. However there were some areas in which the target was met; moving and handling level 1 (100%), resuscitation level 1 (92.6%), health safety and welfare, equality, diversity and human rights (90.2%).

- We were told by staff that the trust's electronic staff record (ESR) which held the data for training compliance was not always accurately updated. For example data provided by the trust showed that none of the staff had completed the new-born basic life support training. However the matron of the neonatal unit provided evidence which showed that 94.29% of neonatal nurses had undertaken a new born basic life support course and 86.49% of the nurses had completed a level 3 safeguarding course.
- Paediatric medical staff group performed worse than average with only 73.3% having completed all necessary mandatory training. For infection prevention and control training only 78.9% of medical staff and 75% of senior medical staff had completed this. Similarly, for safeguarding adults and children, fire safety and information governance, medical staff compliance rates were below average for the department.
- Newly qualified nurses were given eight weeks of supernumerary status which meant they were not expected to contribute to the staffing levels of the ward and instead could focus on learning and developing their new skills.
- Staff told us that they were given time off to complete mandatory training e modules.
- The practice educator had been on maternity leave during the inspection and mandatory training oversight was allocated to the ward managers. The matron of the neonatal unit told us that staff were expected to be responsible for monitoring their own mandatory training records but that ward managers would ask for evidence that the training had been completed and kept a record of any upcoming or outstanding training.
- The trust told us that the majority of staff were PILS (paediatric immediate life support) trained and all of the paediatric consultants have a valid in date PILS (advanced paediatric life support) training. We were told that 30% of staff had undertaken a high dependency care (HDU) course with three or four places per year being funded. Data provided by the trust showed 70.9% of the paediatric staff had completed PILS against the trust target of 90%, and only 44.4% of nursing staff on Rainbow ward had completed this.
- Not all staff caring for children in recovery had PILS training. The trust told us that whilst PILS was not

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mandatory training for theatre staff, in the last 12 months, there have been 38 (out of 91) theatre staff who had completed the training. In addition, 18 out of 21 anaesthetics medical staff had PILS. In the case of a child needing resuscitation and retrieval the anaesthetic team, a paediatrician and a nurse stayed with the child or sometimes in the case of a delay in retrieval, the child would be transferred to the adult ITU where they would be placed in a cubicle to await the arrival of the transfer team.

- The nurses we spoke with told us that their career development was discussed at the annual appraisal and mandatory training was assessed for compliance.

Assessing and responding to patient risk

- We attended handovers in both the neonatal unit and paediatrics and we saw that PEWS and SBAR tools were used as part of the SAFE programme of patient safety. The SAFE initiative recommends the use of communication tools such as the Situation Background Assessment Recommendation (SBAR) technique which encourages good communication. To ensure that staff more fully recognised deterioration in a child we saw that they used Paediatric Early Warning Scores and systems (PEWS). This scoring systems aggregate scores from a range of observations, and the higher the score the earlier an intervention is needed. An early intervention may prevent further deterioration and the need to escalate a child's care either to a high dependency or paediatric intensive care unit. The SAFE handover also covered information related to actual or potential sepsis in individual children through the use of the Sepsis Six bundle.
- Staff safety 'huddles' were at the heart of the children's services SAFE programme and the huddles were the specific intervention that coordinated the primary aspects of the situation awareness. Huddling was used by staff across the units to help share all information about a patient with staff. We saw that huddles included not just nurses and medical staff but other allied health professionals including therapists and play specialists amongst others..
- Staff used PEWS to identify children who needed escalation of care. PEWS was designed to promote the early recognition of deteriorating children. The early warning tools measured aspects of a child's

physiological status including systolic blood pressure, capillary refill time, respiratory rate, respiratory effort, transcutaneous oxygen saturation and oxygen therapy. We saw evidence in the patient records and the bedside charts of the use of PEWS monitoring charts for different age groups.

- The staff we spoke with told us how they used the PEWS charts and matched the score to care recommendations. Staff had knowledge of the appropriate action to be taken when a child PEWS score was elevated and they reported that medical staff responded within set timescales, which ensured that patients were assessed in a timely manner.
- The nursing staff we spoke with were able to describe the processes for escalating emergency issues, such as violence, absconders, safeguarding, Child and Adolescent Mental Health Services (CAMHS) issues, non-accidental injury (NAI) and bed management issues.
- Children's services used the London neonatal transfer service (NTS) or the Children's Acute Transport Service (CATS) to initiate a retrieval for babies or children requiring a period of intensive care. Sick babies and children could be cared for within children's services or the adult ITU until such time as the transfer was expedited.
- Resuscitation and basic life support training formed part of the trust's mandatory training provision.

Nursing staffing

- We were told by the matron of the neonatal unit that there were 6.14 whole time equivalent (WTE) vacancies within the unit with 4.07 WTE vacancies among band 6 nurses and 2.07 WTE vacancies for band 5 nurses.
- Only 56% of the nurses in the neonatal unit were qualified in speciality, this was less than the 70% recommended by the British Association of Perinatal Medicine (BAPM) guidelines. The BAPM seeks to improve the national standard of perinatal care and has developed service standards for hospitals providing neonatal care. The title qualified in speciality (QIS) is applied to those nurses who have achieved a qualification by completing a programme of study in an educational institute that matches the quality standards of the audit tool developed by Health Education England.

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- The head of nursing informed us that the unit was actively recruiting band 5 and 6 nurses with eight new staff commencing within the following three months. There were systems in place such as e rostering and the use of daily huddles for ensuring that the clinical needs of patients were assessed and staffing levels adjusted accordingly.
- Staffing issues were part of the SAFE handover and where clinical need required changes to staffing, the head of nursing was enabled to unlock the golden key for employing agency staff. For example such staffing issues could be exacerbated by deteriorating children who needed high dependency care. The golden key is the official system for unlocking the e roster system to facilitate the employment of an agency nurse when a bank nurse was unavailable. The nurses off duty roster was prepared six weeks in advance and was approved by the head of nursing.
- Safe staffing levels were maintained within the neonatal unit by the employment of bank and agency staff. We were told that the unit regularly employed two or three agency nurses per shift. However the unit always endeavoured to use staff they were familiar with.
- Some members of the medical and nursing staff we spoke with told us that there was an over reliance on the use of agency nurses.
- Although the risks associated with staffing were being controlled and the RCN 2013 standards pertaining to the nurse staffing of children's units and the British Association of Perinatal Medicine (BAPM) standards for staffing neonatal units were being achieved on most occasions, this was achieved through either bank or agency staff use.
- There was always a band 6 or 7 nurse on duty within the neonatal unit but staffing issues were recorded on the risk register and adherence to the 2013 Royal College of Nursing guidance on staffing was only being achieved through the use of bank and agency staff. Bank or agency nurses were therefore used as required.
- At the handovers we attended we saw that there were sufficient numbers of staff available to respond to the acute needs of the children and babies. We observed nurse handovers in both neonatal and paediatric areas and noted that the staff demonstrated a good understanding of patient need, including social needs and relationships with family.
- There was no matron for paediatrics and senior nurses we spoke with found this to be a disadvantage.
- Student nurses told us that some of the shifts were short staffed but not when compared to other children's units they had worked on in other parts of London.
- Staff told us that if there were insufficient staff that the capacity of the ward would be decreased to 20 beds.
- A ward manager told us that five newly qualified nurses had been recruited and that the staffing ratio was currently four patients to one staff member and that 22 beds were operational. There were usually five nurses on day duty in the summer with four at night and six nurses during the winter period with five at night. Additionally a band 4 health care assistant (HCA) was also available. The ward manager was in a supervisory role attending the ward rounds and checking IV's etc. She told us that the head of nursing was highly visible on the ward and that she visited twice per day.
- There was an ongoing recruitment strategy with operations being conducted in Europe and the Republic of Ireland. One band 6 European nurse was not recorded on the nursing and midwifery council (NMC) register as a children's nurse and when we checked the online register she was actually an adult nurse. When she was left in charge of the ward she would have been in breach of the RCN 2013 standards. The ward manager told us that the risk was managed by having a band 6 children's nurse in one of the other units on the floor below.
- Newly qualified nurses received a two week induction and an eight week supernumerary period allowing them opportunity to learn and develop their skills.

Medical staffing

- A consultant presence was always available until 10pm each day.
- There was a named clinical lead for all areas and the attending paediatric consultants had overall responsibility from 8.30am to 10pm with on call availability outside these hours, including weekends. Every child admitted to a paediatric department with an acute medical problem was seen by a healthcare professional on the tier two (middle grade) paediatric rota within four hours of admission and every child was seen by a consultant paediatrician within 14 hours of admission.
- We saw that there were at least two medical handovers every 24 hours are led by a consultant paediatrician and

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that every child referred with an acute medical problem was seen by, or had their case discussed with, a clinician with the necessary skills and competencies before they were discharged.

- The paediatric assessment unit have access to the opinion of a consultant paediatrician at all times
- The neonatal unit was compliant to BAPM medical staffing standards that state a consultant paediatrician should be available in the hospital during times of peak activity, seven days a week.
- Insufficient medical cover was the cause of long waits on the PAU with night cover especially limited. They believe this situation had been made worse by social media forums for parents. The forum had posted information confirming the presence of a consultant paediatrician in the ED which many local parents had found appealing in the absence of out of hours GP services.
- Student nurses told us that there were plenty of medical staff but trained nurses we spoke with felt that junior doctors were overworked and that they all lost weight during their allocation. One senior nurse told us that she thought medical staffing at night was possibly unsafe.
- Safety was enhanced because there was a greater proportion of registrar grade doctors within children's services when compared to the England average.
- Junior doctors we spoke with told us that they were very happy with the supervision and teaching they received. Children's services were a popular choice of allocation. The doctors told us that they had received induction apart from one locum doctor.
- The doctors and consultants had formed a 'whatsapp' group to better manage the off duty roster. WhatsApp Messenger is an E messaging app available for smartphones and is used extensively by doctors to manage off duty especially during periods of staff sickness.

Major incident awareness and training

- The senior nursing and medical staff told us that they had received major incident awareness training. Staff told us that they were aware of the major incident plan and knew how to access the plan via the trust intranet. We inspected the major incident plan and saw that it was in date.
- We saw that winter pressure management plans were in place.

- We saw that the neonatal unit had an emergency planning folder which summarised a range of policies including the major incident plan. We noted that this had been reviewed in August 2016.
- Two of the staff nurses we spoke to did not know about the abduction policy.
- The trust provided all staff with mandatory fire safety training annually. Data provided by the trust showed that not all staff had completed this training with 82.9% of staff compliant versus the target of 90%. Although nursing staff on rainbow ward met this target with 93.8% completing the training, only 80% of neonatal staff had done so. However, the neonatal unit matron told us that staff were up to date with training and the electronic system did not always accurately reflect this.

Are services for children and young people effective?

Good



We rated effective as good because :

- We saw excellent examples of multidisciplinary team working and clinical teams worked together effectively to enhance the provision of care to children.
- The service participated in a range of local and national audits, including clinical audits and other monitoring activities, such as reviews of services, benchmarking, peer review and service accreditation. Performance against a range of national audits was seen to be in line with, or better than, national averages.
- The innovatively designed local curriculum enhanced the ongoing education of junior doctors.
- The use of a nurse led discharge pathways enhanced care.

However:

- The service had not undertaken a "15 step challenge" or a "you're welcome" audit.
- Play specialists support was inadequate and play staff were only available to work with children in a limited number of areas.

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- We found that the pain assessment tools were not always used consistently to identify and measure patient's pain levels.

Evidence-based care and treatment

- Staff told us that that policies and procedures were easily available via the trust intranet.
- We examined a range of policies such as the abduction policy, the winter pressure policy e.g. bronchiolitis and patient escalation policies and all were in date. We also saw that the trust has a specific policy on transitional care arrangement for young people moving into adult services.
- The trust's hospital protocols were positioned around evidence based practice national guidelines and were responsive to current policies from NICE, the RCN and the RCPCH.
- We were shown the nurse led inpatient asthma weaning protocol which included detailed prompts for the management of asthmatic children.
- Significant amounts of research activity were being undertaken within children's services and for example research within paediatric pharmacy on the management of pain in children with sickle cell disease had been published in Archives of Disease in Childhood in 2015
- Clinical governance information and changes to policies and procedures and guidance was conveyed and cascaded to nurses through the head of nursing for children's services via emails and discussion at team meetings. Staff told us that the head of nursing maintained a high profile throughout children's services. We saw evidence that governance issues were regularly presented and cascaded to staff.

Pain relief

- On rainbow ward there was a monthly pain audit which reviewed 10 sets of patients' notes to check whether a pain assessment had been completed using the pain assessment tool. We reviewed six sets of audit results for April to September 2016 and found that the assessment tool was not used consistently for all patients. We also found that the audit itself was not always carried out consistently and that in June 2016 only one set of

records had been checked. Of the 51 sets of records that had been reviewed, 35 showed the pain assessment tool had not been used, of these 20 were noted as 'non applicable'.

- We observed that a variety of tools were used to assess pain, depending on the age of the child and their ability to understand information. The main pain assessment tools used were the Wong Baker 'faces' pain rating scale and the 10 cm visual analogue scale. The faces scale consist of a series of faces ranging from a happy face at 0, "No hurt" to a crying face at 10 "Hurts worst". Young children were helped by the nurse to choose the face that best describes how they were feeling.
- Although there was not a specific paediatric pain team the adult pain team had developed good relationships with the children's services and were especially good at managing the pain of children who were in sickle cell crisis. A sickle cell crisis is a painful episode that occurs in children who suffer from sickle cell anaemia. One of the paediatric pharmacists had taken a special interest in the management of pain in children with sickle cell disease.
- A paediatric pharmacist told us that controlled drug (CD) audits were undertaken every three months with ongoing medicines management audits plus a range of other medicines audits
- Evidence from the documentation audit dated August 2016 showed 0% compliance to the use of the pain tool on Starlight ward and 33% compliance to the use of the Visual Infusion Phlebitis score which is used for monitoring infusion sites.

Nutrition and hydration

- We saw that the Assessment of Malnutrition in Paediatrics (STAMP) were not routinely used and we did not see that plans included an appropriate nutrition and hydration assessment and management plan. STAMP (Screening Tool for the Assessment of Malnutrition in Paediatrics) is a validated nutrition screening tool for use in hospitalised children aged 2-16 years.
- Parents and the play leader told us that children's meals were good. The meals were prepared and microwaved on the ward. The menu gave children a good selection of healthy and nutritious food choices with culturally sensitive food being available.

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- There was good input to the service from the paediatric dietician and snacks and drinks were always available for children at any time.
- We saw that breast-feeding promotion on the neonatal unit was good and that the unit had achieved level 2 UNICEF accreditation. Stage 2 accreditation is achieved when a service demonstrates that all staff had been educated according to their role, and that this training has prepared staff to care for mothers and families effectively.

Patient outcomes

- The service had introduced a '15 step challenge' audit for the neonatal unit but not the paediatric unit. The 15 Steps Challenge is an audit tool to help staff, patients and others to work together to identify improvements that will enhance the patient's experience and was part of The NHS Institute for Innovation and Improvement's productive ward series. The 15 Steps Challenge was a series of toolkits which remain part of the resources available for the productive care work stream. They were co-produced with patients, service users, carers, relatives, volunteers, staff, governors and senior leaders, to help audit care in a variety of settings through the eyes of patients, to help capture what good quality care looks, sounds and feels like. The 15 step challenge is so named after a parent said "I can tell what kind of care my daughter is going to get within 15 steps of walking on to a ward".
- Young people over 16 years of age were admitted to adult wards but the trust had not undertaken a "you're welcome" audit. The Department of Health you're welcome quality criteria were first published in 2005, following concerns regarding contemporary healthcare for adolescents, and a recognition that patterns of health-related behaviour laid down in adolescence impact on long-term health behaviours. An updated version was published in 2011 and established principles that enable healthcare professionals working in children's services and elsewhere to improve services by making them younger person friendly.
- Weekly notes audits were carried out within the neonatal unit and the children's unit where one of the band 7 nurses checked five sets of notes to ensure that all entries met current standards.
- We saw that there was a monthly Laming audit undertaken and staff had published the results of some of these in the Archives of Disease in Childhood journal. Between 2007 and 2015, six audits of the Laming recommendations were performed on the unit and each audit examined 30 sets of notes in which safeguarding concerns had been raised.
- Other audits included a hypoglycaemia and neonatal vitamin audit on the neonatal unit, an audit of pain management in sickle cell disease and audit of prednisolone tablets versus soluble tablets (audit of effectiveness).
- The glycosylated haemoglobin (HbA1c) measurement is recognised as being the best indicator for long-term diabetes control and data from the trust showed that children with diabetes who are cared for within children's services at North Middlesex Hospital had less better controlled diabetes management than that experienced elsewhere in England. The multiple rate of admission for children with diabetes was 22.5% which was worse than the England average of 13.6%.
- We saw that the children's services participated in the Epilepsy 12 audit data collection. This National Epilepsy 12 Audit was developed by the Royal College of Paediatrics and Child Health to determine how effectively national recommendations for the management of epilepsies in children and young people were being followed by providers. The aim of this national audit was to assist epilepsy services, and those who commission health services, to measure and improve the quality of care for children and young people with seizures and epilepsies. We inspected the data for multiple readmissions of children and young people with epilepsy which was 29.6%, which was comparable with the England average of 29.4%.
- Performance against the national clinical audit for paediatric asthma was slightly worse than the England average with multiple admission rates for children being 17% compared to the England average of 16.5%. This audit involves the collection of data on every child over one year of age admitted to hospital with wheezing or asthma during the month of November. The data collected is grouped into five areas: basic demographic information such as age and sex; initial hospital assessment; initial hospital treatment; discharge treatment and asthma attack management planning; and plans for follow-up.

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- We saw that the neonatal unit was meeting the requirements of the national Badger net audit and when we inspected the database we noted that it was fully updated. This electronic system has been designed to provide a repository for the collection, storage, and reporting of live perinatal patient data.
- The outpatient department had robust procedures for dealing with patients who did not attend (DNA). We examined the DNA policy and saw that it was effective in dealing with children who failed to attend outpatient's appointments. The policy ensured that patients were offered subsequent appointments and also responded to any safeguarding concerns. The outpatient department had between seven and eight clinics per day covered by 15 consultants. The adjacent PDAU had four funded beds/cots and offered care for up to 30 children per day for example for sickle cell blood transfusions, methotrexate injections for children with rheumatoid disease and chemotherapy under shared care arrangements. All patients attending the department were contacted the day before using SMS texting.
- The outpatient department hosted a dedicated child phlebotomy service but only in the afternoons Monday to Friday from GP referrals, community clinics and other children's clinic's elsewhere in the hospital.

Competent staff

- Staff reported that they had attended induction on starting employment and had attended mandatory training, including basic life support. Agency nurses and agency health care assistants we spoke with told us that they had attended induction prior to commencing duties within children's services.
- The education budget was held by the trust. All newly qualified nurses were entitled to a preceptorship year and a rotation scheme was in place which included the paediatric ED.
- Staff were enabled to progress their careers through the attendance of educational courses in local universities which were discussed at their annual appraisal and nurse revalidation was firmly established. Financial help was available for nurses to complete local university courses.
- Some nursing staff on the neonatal unit were enabled to attend programmes of study leading to the recognition of 'qualified in specialty' status (QIS). These post registration education pathways, in collaboration with service providers, allow for registered nurses working in neonatal units to become equipped with the specific knowledge and skills to practice safely and effectively in this critical care area.
- Consultants we spoke with told us that arrangements for medical revalidation were fully embedded within children's services.
- The majority of staff within children's services received annual appraisals from their manager. Data provided by the trust said that 86.4% of staff had an in-date appraisal as of August 2016. The trust target for appraisals was 80%.
- We saw on the neonatal unit examples of the staff training matrix which the practice educator and ward managers used to ensure that renewal dates of training were met.
- Clinical nurse specialists (CNSs) for various specialities including for diabetes were in post throughout the service.
- On Starlight ward there was always a nurse with a PILS qualification and occasionally someone with APLS. The staff of Starlight ward had responsibility for both the short stay ward and the PAU.
- Not all of the theatre recovery nurses had a PILS qualification. The trust told us that PILS was not mandatory training for theatre staff but that 42% of staff in theatres had completed this training in the past 12 months.
- We examined the paediatric curriculum for junior doctors which was very well established and carefully orientated to meet the training needs of junior doctors. Junior doctors we spoke with all told us that they received high quality educational support from their consultants and at the medical handovers we attended we saw that consultants used the occasions for impromptu teaching of junior colleagues.
- Children's services failed to meet the play requirements of children as set out by the National Association of Health Play Specialists by The ensuring that play workers were appropriately trained to the required standard.

Multidisciplinary working

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- Overall, staff reported, and we saw examples of, good multidisciplinary team (MDT) working across the children's services.
- On the neonatal unit we saw the agenda for the August 2016 team building meeting which had been introduced in May 2016. We examined a selection of feedback forms which had been completed by staff and these were mainly positive.
- Ward rounds within the neonatal unit and children's wards were multidisciplinary and staff were encouraged to attend the MDT psycho social rounds
- Feedback from student nurses allocated to the neonatal unit was good and we saw that they were included at MDT meetings and felt able to contribute to discussions.
- At the handovers we attended where the SAFE procedure was used we saw that MDT working was good with attendance by among others student nurses and a play specialist.
- There were good links to local GPs through the use of email and the trust had developed pathways of care for GPs to follow. GPs also had access to the GP hotline into the PAU which was managed by a consultant and allowed them to seek advice and refer patients if necessary.
- Patient safety and service quality meetings which were multidisciplinary were held monthly.
- The play leader told us that "this is the best paediatric team I have ever met". The play leader also attended the weekly psycho social MDT meetings led by the consultant of the week. We attended this meeting and observed that the play leader contributed valuable information to the discussion about patients' care and treatment and that this was acknowledged and taken into account by the team. There were 11 members of the MDT in attendance including the play leader, social workers, psychologists, nursing staff and the safeguarding leads. At the meeting children with complex needs were fully discussed. We saw that all members of the team were treated equally and encouraged to contribute.
- Student nurses told us that the staff were very friendly and welcoming and that they had witnessed good MDT working. "Everybody gets along and they are really good with newly qualified nurses". Student nurses had been allocated mentors and the NMC rules for mentoring were being achieved at all times.
- The ward manager we spoke with told us that MDT working was the best she had ever seen in her career.
- The dietitian we spoke with on the neonatal unit felt very much part of the MDT.
- There was no access to a learning disability specialist nurse and children with additional support needs were not clearly identified.
- One of the consultant paediatricians who had worked there for six years told us that the unit appealed to junior staff as it was a busy unit and gave them good experience. For example there had been seven resuscitation calls over the previous 24 hours. She thought that inter-professional and multi-professional working was very good and she believed the staff worked hard and also socialised together which helped with team building.
- The full time paediatric physiotherapist had left the service and her replacement was a temporary bank physiotherapist. Although she had only been employed for a short time she had found that MDT working was good although she commented on the shortage of play specialists.

Seven-day services

- Pharmacy cover for the service was available Monday to Friday with a weekend service between 9am and 4pm, outside of these hours there was an on call service.
- The ward paediatric physiotherapist had left but an agency physiotherapist had been employed until the replacement arrived. However they were only available Monday to Friday, 9am to 5pm.
- There were no qualified play specialists employed by children's services and the three play workers (with one on maternity leave) were only available to work with children during the working week with no weekend or evening cover.
- The senior nurse in the outpatient department told us that the clinics were mainly held Monday to Friday. Although a multidisciplinary paediatric psychology service was provided on site which incorporating

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psychology, psychotherapy and psychiatry, access to this service was through a consultant referral only. Child and adolescent mental health services (CAMHS) were only accessible during the working week and children admitted with mental health conditions over a weekend period had to wait until the following Monday to access support.

Access to information

- All the information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way through care and risk assessments, care plans, case notes and test results.
- When patients move between teams and services, including at referral, discharge, transfer and transition, all the information needed for their ongoing care was shared appropriately, in a timely way and in line with relevant protocols.
- There were a large range of bespoke specific information leaflets available in all departments for families. Although these were available primarily in English facilities were available for their translation into other languages
- We saw that doctors and nurses gave information to families using language that they could understand and the parents we spoke with told us that they liked the way in which staff communicated with them.

Consent

- The parents we spoke with in children's services including the outpatient department told us that their consent had been sought prior to treatment of their child and that the nurses or doctors had asked for the child's agreement before performing any procedure. For example during our visit to the operating department we saw that children undergoing anaesthesia were asked by the anaesthetist for their consent before administering the anaesthetic which helped put the child at ease.
- Parents described how the procedures had been explained to them by both doctors and nurses. They felt they had been given very clear information and were well informed before they signed the consent form for surgery and or treatment.
- All the medical and nursing staff we spoke with were able to describe to us the legal aspects of consent. They were all aware of the policies and procedures that were

available to them to ensure that informed consent was obtained from children and their parents or carers. Similarly, staff fully understood the Gillick competence and the arrangements for seeking consent from children and young people where they had been assessed as being competent to make decisions regarding their care and treatment. However, an 11 year old child and family awaiting day surgery told us that they had been given full explanations about the forthcoming orthopaedic procedure but the child was not asked to sign the consent form despite being competent to do so.

- We saw that patient records contained notes which confirmed that staff had conducted full discussions with family members and had recorded their consent within the record.
- Staff were aware of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and were able to describe the arrangements that were in place should the legislation need to be applied.

Are services for children and young people caring?

Good



We rated caring as good because:

- Family centred care was evident throughout the service. We saw that staff demonstrated compassionate care and treated patients and their families with dignity and respect.
- The parents we spoke with were pleased with the care their children had received from the medical, allied health care professionals and nursing staff and they told us that they felt that their children were in a safe place and that their needs would be met at all times by staff.
- Parents told us that they were fully involved in the care delivery for their children and that health care professionals kept them informed at all times as to the progress of their children. We saw that there was compassionate and caring staff interaction at all times with the children and their families.
- We saw that friends and family test results were 100%.

However:

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- The 2014 children's survey results demonstrated that the trust performed worse than other similar trusts in the majority questions asked.

Compassionate care

- Throughout our inspection, we saw good staff interaction with patients and parents. We observed good, friendly and appropriate communication by nursing and medical staff with parents and their child. Nurses and other members of the MDT we spoke with told us that children and their families were always treated with the utmost respect.
- We saw staff members introducing themselves to families and giving clear explanation to both children and their parents.
- Parents were able to visit the neonatal unit at all times with other visitors being allowed to visit between 3pm-5pm and the parents told us that they were very happy with care on the neonatal unit.
- We noted that bereavement support was available and that there were links with other teams and the local children's hospice Haven House. We also saw links among others to other charities such as Bliss, the neonatal charity and SANDS the stillbirth and neonatal death charity.
- The weekly 'tea break' meeting on the neonatal unit was much appreciated by parents as it gave them an opportunity to discuss their experiences with other parents in the same position.
- We saw that the whole service had embraced compassionate care and this was evident throughout. Each cubicle had a laminated caring "my wish list when I am in hospital" which consisted of 13 caring prompts for staff including "please knock on my door before you come in if I am in a single room" and "please say hello or good morning with a smile" among others. This was to promote family centred care and had been initiated by the head of nursing.
- The medical and nursing staff told us that they would be happy to have their own children admitted to children's services and we saw that all the staff were aware of the 6C's and believed that it was embedded into their own ethical practice. The 6Cs are a set of values that underpin compassion in practice, namely care, compassion, courage, communication, commitment and competence.
- Parents we spoke with in the PDAU told us that the nurses helped to put them at ease and we observed that when staff interacted with worried parents that they did so with smiles and reassurance on their faces. One mother told us that she loved the nurse caring for her child because she was very caring and explained everything she was going to do at all times.
- We noted that compassionate aspects of care were discussed at MDT and huddle meetings that we attended.
- Parents we spoke with were highly complementary about care delivery and for example one mother told us how a nurse had ordered food and drink for her child with a learning disability who had been admitted to the ward having missed her breakfast.
- Parents and children from ethnic minority groups in the outpatient department told us that staff always spoke to them using language that they could understand and that the nurses always addressed them and their children by their names. Parents told us that the department was child friendly and that the nurses were kind.
- The play leader had knowledge of children who were self-harmers and she told us that such patients were quite common especially during exam periods. The play leader confirmed that children with self-harming behaviour were fully discussed at each handover and that all staff were aware of their duty of care in keeping items such as scissors out of sight.
- Student nurses told us that they would be very happy for their own children to be cared for within children's services. Furthermore they told us that feedback from parents was overwhelmingly positive compared to other unit's they and worked in and that staff were "100% caring".
- One mother in the PAU was not happy with the care she had received and told us that the nurse had not introduced herself and that she had waited since presenting at the ED at 7.30 am and at 10.45 am was still

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waiting to see a doctor. Although she was breastfeeding she was not offered a drink although a water fountain was available. However the doctor concerned was actually in resuscitation with another patient.

Understanding and involvement of patients and those close to them

- During our observations we saw numerous examples of members of the multidisciplinary team including pharmacist and allied health care professionals involving children and their families in their care.
- Parents told us that were given appropriate information on all aspects of care by each member of the multi-disciplinary team they had contact with. However some non-English speaking parents told us that they were frustrated at the lack of translators Information was given in a child friendly format and we saw doctors and nurses engaging children in dialogue which was couched in language they could understand.
- We saw that theatre staff took great care in explaining to both parents and children what was about to happen.
- An 11 year old child and family awaiting day surgery told us that they had been given full explanations about the forthcoming orthopaedic procedure. The mum was very happy to recommend the service to a friend.
- We observed how the nurses prepared children and their families for surgery putting them at ease and when we accompanied one child and his parent to the operating theatres we saw that the anaesthetist involved them fully during the period in the anaesthetic room which had been decorated to make it child friendly. We observed the theatre staff fully involving the child in conversations which were age appropriate. The anaesthetic staff spoke to him in language he could understand and asked for permission from him before going ahead with procedure. The anaesthetist explained each step of the procedure to both the child and the father .The father was accompanied back to the ward by the nurse.
- Data from the children's survey in 2014 showed that children's services at the trust performed worse than other comparable trusts in the majority of areas. These included privacy, dignity, access to play materials, active listening by staff members, and perceptions of care delivery by hospital staff. Other areas of care which fell

below that delivered by similar trusts included explanations by staff of what was going to happen to children receiving care, the use of language parents could understand, parental involvement in care and the availability of information leaflets.

- Our discussions with parents did not uphold these perceptions and on the whole parents we spoke with were very pleased with all aspects of caring within the service and we saw that friends and family test results were 100% for August 2016.

Emotional support

- Although we saw that there was a lack of play support within the service as a whole we did witness the play staff putting out toys within the PDAU and at the commencement of the outpatient clinics.
- We saw that a range of healthcare specialists including community nurses and psychologist were available to provide emotional support to families and to children. Bereavement support was available and we saw that a strong links with the local hospice and other members of the care team.
- We saw that there were a range of clinical nurse specialists in post and that CAMHS services were available during the working week but not at weekends to respond to the emotional needs of children with mental health conditions.
- Rainbow ward had a small hospital school which provided educational support for patients. This helped provide emotional support to children by providing the normality of doing something familiar and an opportunity to express themselves through learning and play.

Are services for children and young people responsive?

Requires improvement 

We rated responsive as requires improvement because:

- There was poor oversight of patients living with learning disabilities. There was no children's learning disabilities nurse and patients were not identified or flagged on admission. There was a lack of play provision.

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- The trust had not assessed whether it was young person friendly through the undertaking of a “you’re welcome” audit and with no corporate oversight of young people in the trust or children in other areas out with children’s services.
- There was a lack of specialist nursing staff to provide effective asthma and allergy clinics. Patients were waiting a long time for appointments and in some cases not receiving follow-up appointments.

However:

- Youth workers were employed within the emergency department to help address issues such as youth violence. Gang-related violence had been identified by the trust’s safeguarding team as one of the key risks to young people within the local population.
- We found that the trust’s sickle cell disease service was responsive to the needs of children and young people. There was a good practice protocol that included a young person’s self-assessment that was designed to help them work with the healthcare team to manage their transition to adult services.
- Staff exhibited high awareness and management of female genital mutilation.
- We found good parent accommodation facilities.
- Referral to treatment times reported by the department for the six months April to August 2016 showed that the majority of patients were being seen within the 18 week target. Between 94.47% and 99.1% of patients had been seen within 18 weeks of referral.

Service planning and delivery to meet the needs of local people

- We were told by the community nurse specialist we spoke with that the trust employed 7 WTE clinical nurse specialists for epilepsy, sickle cell disease diabetes, allergy and HIV. However, the trust risk register states there was no paediatric allergy nurse employed by the trust, which compromised adequate care and treatment of children. The trust recognises that the current waiting time for a new patient appointment within the allergy clinic is not acceptable. As recorded on the risk register there was currently an eight to nine month wait despite national guidance suggesting this needs to happen within three months. The clinic was being covered by

one 0.6 WTE nurse who was employed for Haringey community work. We were told that a business case had been submitted to request a full-time allergy nurse be employed.

- The risk register also recorded that there was no asthma nurse within the department. As a result the majority of the recommendations made by the National Review of Asthma deaths are not being complied with and there was no appropriate follow up of patients putting them at risk. The trust were awaiting for a response to their business case submitted to the CCG.
- We saw that the sickle cell service was under pressure due to staff illness but was being well risk managed and was recorded on the risk register.
- A paediatric community nursing service covered the local boroughs and a lone worker policy was in place.
- The SAFE huddles took place at each shift which allowed the staff to discuss among others their bed occupancy, post-operative management, upcoming discharges, elective and emergency admissions and safety issues.
- Although the transition of young people to some adult services was well-managed by the department we found that generally young people over 16 years of age were not cared for within the children’s service and that there was no oversight of their wellbeing within the trust.
- We saw evidence that the transition of children and young people into some adult services including adult sickle cell disease service was managed effectively. We saw that the trust had developed a good practice protocol for children in transition with specific long-term conditions. This included a young person’s self-assessment that was designed to help them work with the healthcare team to manage their transition to adult services. This was an integral part of the sickle cell service for young people.
- The children’s survey of 2014 showed that the service performed as well as other similar trusts in providing facilities for parents to stay overnight.
- Gang-related violence had been identified by the trust’s safeguarding team as one of the key risks to young people within the local population. The employment of

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youth workers in the ED has been positively received and had helped address issues including youth violence by helping the trust work closely with the police and other support agencies.

- The safeguarding board was committed to improving engagement of children and young people in its work to improve its understanding of children's and young people's experiences of safeguarding and their priorities.

Access and flow

- The trust provided us with 'referral to treatment' (RTT) information for April to August 2016 for both "incomplete pathways" which are waiting times for patients waiting to start treatment at the end of the month and for "non-admitted pathways" which are waiting times (time waited) for patients whose treatment started during the month and did not involve admission to hospital. This showed that the majority of patients were being seen within the 18 week national target. Between 94.47% and 99.1% of patients had been seen within 18 weeks of referral. For patients whose treatment started during the month and did not involve admission to hospital more than 95% of patients had waited less than 18 weeks.
- The multidisciplinary team conducted twice daily huddles and ward rounds to review the ongoing care needs of children including discharge planning for each patient.
- Parents within the outpatient department told us that outpatient referrals were not always timely and that sometimes they had to wait several months for an appointment. Parents we spoke with in the outpatient department told us that outpatient referrals were not always timely with one mother citing a five month wait for her son to see a dermatologist. The lack of capacity in the outpatients department was recorded on the risk register and it was noted that the introduction of new rapid access clinics in the autumn may help with some of the new referrals but it was also recognised this would have limited impact on wait-times.
- The unit always tried to accommodate all children but if no beds were available children were transferred out to

other providers via incident reporting. Other strategies to alleviate bed pressures such as early discharge after consideration by the duty doctor were also considered in such circumstances.

- We were told that some discharges had been delayed because of long term social care issues.
- We saw that there were shared care oncology management with other London tertiary centres where joint discharge planning meetings took place.
- We saw that Starlight ward, which housed the PAU, had a sophisticated access and flow tool which gave details of admission via the accident and emergency department, via a general practitioner referral or self-referral via families with pink (long term condition) passports.
- The outpatient 'did not attend' (DNA) rate was seen to be well managed with procedures in place to ensure that children came to no harm from conditions which might deteriorate over time and become exacerbated by a failure to attend monitoring clinics. The trust provided us with the DNA rates for all paediatric clinics for the six months February to July 2016. The overall DNA rate for all clinics varied between 12% and 16.1% with an average of 14.7% for the six-month period. On average new patients had a higher DNA rate at 17.2% compared to patients returning for a follow-up at 13.4%.
- We saw that a phlebotomy service for children operated from the outpatient department.
- Some clinics, for example ophthalmology and fracture clinic operated from adult departments and were not especially child friendly with no oversight from children's services.

Meeting people's individual needs

- The neonatal unit had introduced a weekly tea meeting held every Thursday for the parents on the neonatal unit where parents could talk to the pharmacist, the dietitian and nursing and medical staff and receive peer support. Mothers on the neonatal unit received good support for managing breast feeding.
- Three of the cubicles on the neonatal unit were used for the delivery of transitional care where the community nurses could spend time helping parents get ready for the return home with their babies.

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- The Iris clinic for FGM continued to provide a good service. One of the consultants told us that “child protection is an outstanding service here at North Middlesex”.
- Link nurses were in post in all areas of children’s services most and were responsible for a range of policy implementations including safeguarding and infection control.
- A range of informative posters for parents were strategically placed around the clinical areas.
- A play leader who was a nursery nurse told us that no play staff were qualified as hospital play specialists. There were three play leaders but one was on maternity leave. The play service operated 8 am till 4pm with some 8am till 6pm service and no weekend service. Where play leaders were available they provided distraction via starlight distraction boxes that are filled with toys, games and puzzles to help children cope with various medical procedures. They could be used by nurses and play specialists, and they are an important and effective distraction technique. In addition to having access to computer tablets for undertaking diversional activities such as “where’s wally?” (electronic or paper books which consist of a series of detailed double-page spread illustrations depicting dozens or more people doing a variety of amusing things at a given location and child readers are challenged to find a character named Wally, an effective diversional technique). Children’s services had invested in a three dimensional child distraction unit which was used by children of all ages before and after procedures. However, there were insufficient play staff and no hospital qualified play specialists to meet the standards of the NSF or the National Association of Health Play Specialists which is a charity which aims to promote high professional standards for play staff, and to ensure the provision of appropriate therapeutic and stimulating play in hospital.
- Although there was no play budget for buying toys one of the play leaders had personally undertaken a charity challenge and had raised £4,500 for children’s play facilities.
- The playroom was well equipped and adjacent to the schoolroom. However, we saw that older children were not always well supervised in the playroom and that limited play staff made this difficult.
- Play leaders could be booked to offer distraction to named individual children on both Rainbow ward and Starlight ward. The play leaders also set up toys every morning for use on PAU and outpatients.
- No specific staff had been trained to offer care communication interventions to children with learning disabilities although one of the play leaders had some basic knowledge but not the ability to use Makaton or PECS. Makaton is a Speech and Language programme that uses a multi-modal approach of speech, signing and symbols to support the communication of children and PECS (Picture Exchange System) is another communication strategy for children with learning disabilities which uses pictures to represent the voice of the child. However there was a sensory toy cupboard which staff could assess to source sensory toys for children with cognitive impairments.
- Children were given educational support five days a week during term time and the teaching assistant gave a choice of subjects for the children to choose, depending on their age group. All activities were documented in accordance with education guidelines. At the time of the inspection the qualified school teacher had left the service.
- Although there was a clinical nurse specialist within the trust for learning disabilities, this was an adult service only. Children with learning disabilities were not flagged.
- There was no oversight by the paediatric team of young people aged 16 to 19 who were admitted to adult units.
- The theatre recovery was a combined adult and child recovery area. However the allocated bed space for children was out of sight of the adult area and separated by a curtain. This reduced the risk of exposing children to upsetting sights.
- Although translation facilities were available some parents felt that the service could be better although there was a dedicated person to liaise with Turkish families. A Turkish link worker had been employed and details were available on the ward notice board.
- The children’s menus included cultural dishes reflecting the local community and snacks were available at any time. Additionally staff were able to offer children snack

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boxes at all times of the day containing for example sandwiches, fruit and drinks. Parents we spoke with told us that they were offered drinks on admission and that their children were offered snack boxes.

Learning from complaints and concerns

- Between July 2015 and July 2016 the trust received 11 complaints for children and young people's services. Five were about aspects of clinical treatment, two about admissions/discharges/transfer arrangements, two about staff attitude and two about communication with patients. Only three of these complaints were fully upheld by the trust.
- Almost half of the complaints received related to all aspects of clinical treatment. These complaints were generally about the overall care received. One of the complaints related to a baby that was sent home with a broken arm without the parent being told on discharge. This complaint was still under investigation.
- We saw that complaint levels within children's services were generally low and the staff we spoke with told us that they always endeavoured to resolve issues in the first instance by speaking with family members.
- All concerns raised were investigated and any learning from complaints was shared with the whole team to improve the family experience within the service. We saw that the trust used a helpful newsletter entitled "Burning Issues" as part of its trust wide mission of "putting people first", to cascade information to staff about complaints. We looked at a copy of Burning Issue 2016 number 2 which gave details of the single complaint which was made during that period. (This related to the printing of amended discharge summaries for parents and general practitioners).
- We saw the 'patient status at a glance' boards were in place. These were used to display important patient information such as how complaints had been addressed in addition to other elements such as the number of occupied beds and the nursing and medical teams on duty.

Are services for children and young people well-led?

Requires improvement 

We rated well led as requires improvement because:

- There was no children's board and no named children's champion to represent children across the trust or a non-executive appointment to represent children within the overall executive board.
- Although the trust had a strategy for children's services, there was no trust-wide strategy for the care of young people aged 16 to 18 years and we found a lack of oversight of both children and young people who are seen and treated outside of the children's department.
- Public engagement was limited and the trust not implemented a 15 step challenge within the paediatric unit nor a 'you're welcome' audit cross the trust to engage with young people.
- It was not always evident that all staff groups were listened to in relation to their concerns. For example, the senior paediatricians had raised concerns about the lack of a children's board

However:

- There was good local medical and nursing leadership within children's services with a committed and highly collegiate group of senior staff.
- Staff told us they had confidence in the leadership of the new executive team.

Vision and strategy for this service

- The trust had developed a strategy for the future development of children's services which included a range of aspirations:
 - To further develop non-elective services that support the right care in the right place working across primary and secondary services
 - To enhance specialist services in diabetes, asthma, allergy and sickle-cell working in collaboration with Primary care
 - To increase HDU provision in paediatric and neonatal services
 - To work towards and to achieve Level 2 POSCU status (Paediatric Oncology Shared Care Units)

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- To further develop transitional care provision
- The management team for children's services told us that they aspired to provide the best service possible but that this vision was potentially compromised because the paediatric emergency department was not part of children's services. Additionally they believed that the closure of the emergency department (ED) at another local hospital had put extra pressure on the service. This had been partly mitigated by the employment of an additional two paediatric consultants in the ED.
- The services of the Good Governance Institute has been enlisted to improve governance across the service and the management team were considering the use of dashboards across the service to further cascade clinically related information.
- Local leadership was compromised because there was no matron in post for paediatrics
- Despite National Service Framework recommendations the trust did not operate a specific children's board. The trust had not appointed either a children's champion or a non-executive lead for children to represent them at board level. Consultants and other staff were actively lobbying for the development of a children's board.
- Staff we spoke with told us that they received regular emailed correspondence about changes within the trust and that the new management team had been highly visible one staff member who had worked in the trust for many years told us "we are now in a better place" and that the new managers had visited Starlight ward.
- Student nurses were very supportive of the management structure "If they had a vacancy I would run for it" said one.
- Student nurses told us that they were well supported by visiting lecturers from their university.

Governance, risk management and quality measurement

- Four consultants had received Root Cause Analysis Training and there were regular Children's services quality and governance meetings.
- The risk register clearly identified risks to the services and tangible plans to mitigate risk had been implemented.
- The implementation of the RCPCH SAFE programme was important in local risk management and all the staff we spoke to were very supportive of the safety huddles.

Leadership of service

- Services for children and young people, along with women's services, formed part of a clinical business unit (CBU) headed by a clinical director and supported by a managing director and deputy clinical director for paediatrics. The head of nursing for children and young people's services reported to the managing director and was supported by the neonatal matron and ward managers. There was no separate paediatric matron post at the time of our inspection and the head of nursing carried out the responsibilities associated with this role.
- All the staff we spoke with told us that they valued and were very fond of the head of nursing and that they received excellent care and support from their senior colleagues.
- The management team had recognised that there were significant shortfalls in optimum staffing across children's services and steps had been taken to resolve some of these issues.

Culture within the service

- Staff nurses told us that senior staff were welcoming and supportive and that there was an absence of bullying or discrimination.
- Some of the nurses we spoke with had worked in children's services for many years and found the culture to be very supportive.
- There was an open culture amongst the staff who felt confident to report incidents and concerns in all clinical settings where a high reporting and low harm culture was encouraged.
- Staff we spoke with were very supportive of the new links with the Royal Free Hospital Vanguard.

Public engagement

- Public engagement was still in the early stages of development and children's services had not implemented a 15 step challenge within the paediatric unit nor a 'you're welcome' audit cross the trust to engage with young people. Although the service used the friends and family test to gather information from families there were no specific ways to reflect immediate feedback from inpatient families.

Staff engagement

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- It was not always evident that all staff groups were listened to in relation to their concerns. For example, the senior paediatricians had raised concerns about the lack of a children's board.
- The star of the ward nominations were highly valued by staff and helped make staff feel valued for working within children's services. The trust had launched the star initiative which was based on the values of the trust namely, caring, helpful, open and honest teamwork. The star of the month scheme was designed to celebrate the contribution of individual staff members in upholding these values.

Innovation, improvement and sustainability

- The clinical teams used the SAFE (Situation awareness for everyone) programme. North Middlesex Hospital had been one of 28 hospitals which had worked with the Royal College of Paediatrics and Child Health (RCPCH) in participating in a two year programme to develop and trial a suite of quality improvement techniques to improve communication, build a safety-based culture and deliver better outcomes for children and young people, known as SAFE. The SAFE programme was designed to reduce preventable deaths and error occurring in the UK's paediatric departments.

End of life care

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

Information about the service

End of life care (EoLC) relates to patients who have been identified as having entered the last 12 months of their life or less. It refers to care of patients in the final hours or days of their lives, and to the care of all those with a terminal illness that has become advanced, progressive and incurable.

The end of life care team was small within the trust . There were three clinical nurse specialists that reported to a lead nurse and three part time palliative care consultants that reported to a lead consultant and a clinical director. Both leads reported to the medical director and the director of nursing.

Other teams within the hospital that were part of end of life care were the ward staff and medical teams, chaplains, bereavement officers, patient advice liaison officers (PALS), mortuary staff and the porters.

Dedicated EoLC services were provided by the trust Monday to Friday between 9am and 5pm. There was no out of hours cover for the service.

During our inspection, we spoke with 18 patients and six relatives who described the level of care and service they had received from the trust. We visited a variety of wards, these included Podium 1, T3, S2, ASU, ED to name a few to gather information. There were no dedicated EoLC wards within the trust. We also visited the porters office, the bereavement office and the mortuary.

We reviewed patient records and specifically do not attempt resuscitation (DNACPRs) orders as well as palliative and end of life care records.

There were 1085 deaths at the trust within the past 12 months.

End of life care

Summary of findings

We rated this service as requires improvement because:

- The Royal College of Physicians states there should be a minimum of 1 WTE palliative care consultant per 250 beds. This means the trust was not meeting the minimum requirement set out as it only has a total WTE of 1 for 384 acute adult inpatient beds.
- NICE guidance for EoLC staffing stated a seven day service should be provided for EoLC, however this had not occurred. A business case was awaiting review.
- Complaints regarding the palliative or end of life care service were not being coded correctly, therefore there was a lack of awareness of concerns or complaints.
- Incidents were recorded on the electronic reporting system used by the hospital although the same type of incidents reoccurred on a number of occasions. This suggests no learning was taken from the incident to prevent it reoccurring.
- There was no clear EoLC strategy. The specialist palliative care team (SPCT) were aware of improvements required within their service however they felt these were due to trust financial constraints.
- There was inconsistency found in DNACPR audits and no clear action plan to address the issues found.
- Bereavement surveys were not carried out, therefore the trust could not monitor or benchmark its performance against other providers. The trust was now collaborating with other partners to introduce a London wide questionnaire, however this was still in the initial stages.
- Mental capacity forms were not always completed for patients that lacked capacity and had a DNACPR order completed which was against trust policy.
- Advanced care planning was not always taking place for patients and this was recognised by the trust as an area for improvement and had been included in a trust-wide EoLC teaching programme since 2015.
- The risk register had only recorded one risk, although there were other concerns identified during our inspection. The risk register was not kept up to date.
- We observed poor patient care and felt this was improved but not to a standard that was fully appropriate.

However:

- Pain was managed appropriately and in a timely fashion. Records showed patients were monitored for signs of deterioration by completion of the national early warning score (NEWS) tool.
- The mortuary had clear records and traceability for deceased patients.
- Bereavement officers were compassionate towards bereaved relatives and were able to give good advice and guidance.
- A minimum of 50% of registered nurses on every ward had received some form of training from the SPCT. This was the trust target.

End of life care

Are end of life care services safe?

Requires improvement 

We rated safe as requires improvement because:

- EoLC incidents were not coded correctly therefore the trust were not accurately recording or investigating concerns or complaints.
- The post mortem (PM) suite was non-compliant with HBN 00.09 regulations and the Hygiene Code.
- The portable equipment within the mortuary had not been safety tested since 2012.
- From the training records provided, there was a lack of nurses on certain wards trained to use syringe drivers to deliver medication to palliative and end of life care patients
- Mandatory training for the specialist palliative care team (SPCT) was unable to be verified as it was not dated and did not include all members of the team
- Patients prescribed care plans as written within their patient records was not adhered to and this was observed at two separate inspections to the same ward.
- There was no trigger system available for use to assist clinicians to decide when referral to the SPCT would be appropriate, therefore some complex patients that may have benefited from referral did not have a consultation provided.
- The lead consultant for the SPCT calculated the need for five CNS's to be substantive within their team to enable a seven day service in line with NICE guidance for staffing. At the time of our inspection there were two substantive CNS's with a third joining at the end of October 2016. An advert had been placed for the fourth vacancy, however there was no funding for a fifth CNS to be provided.
- The hospital had 515 beds. The Royal College of Physicians recommends that there should be a minimum of 1 WTE palliative care consultant per 250 beds. This means the trust was not meeting the minimum recommendations as it only had a total WTE of 1 consultant.

However:

- The Individualised Priorities for End of Life Care (iPELC) document had been introduced by the trust to replace the Liverpool Care Pathway. This provided a document to record EoLC decisions and prompt clinicians during decision making.
- We observed the national early warning score (NEWS), Waterlow chart and the malnutrition universal screening tool (MUST) being used in all patient records.
- The mortuary showed good record keeping and safeguards for deceased patient processes.

Incidents

- All staff we spoke with were familiar with the electronic reporting system and how to navigate this. They were able to give examples of when they had used the system to report appropriate incidents. Staff received an email acknowledgement.
- Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. There were no reported never events or serious incidents between August 2015 and July 2016. During the inspection we looked into this further. The hospital explained there had been a problem with their complaints coding system, therefore the end of life care complaints had not been correctly identified. We were assured by the hospital this situation had been rectified, and they were working closely with the complaints department to monitor the situation. During the inspection, we were not informed of any never events or serious incidents that should have been reported during the previous year to date.
- We inspected the mortuary department and found there were a number of incidents that had been reported. This included incorrect paperwork and ward staff and porters not always following procedures. The mortuary had reported these incidents and they had been acknowledged, however outcomes of the concern or investigation were not shared with the department or complainants.
- A number of incidents had been reported on the hospitals incident logging system. This was separate from the electronic reporting system. Outcomes and

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action plans were recorded, however the action plan did not name a specific person to take control of the situation nor did it state any timescales for the actions to be completed.

- A large number of incidents recorded by the mortuary staff were very similar. No learning had been fed back to the relevant departments as the same issues had continued to occur.
- We looked at a number of incidents that were reported and their outcomes, we found the action plan did not always include further training or learning for those directly involved within the incident. In these situations we noticed the same issues occurred a number of times over the past year, therefore the hospital had not addressed the issues.
- Staff told us that they were happy to report incidents and concerns, however management were not always happy with the large number of concerns raised.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. All the staff we spoke with during the inspection had a clear understanding of their responsibility towards patients and their relatives if there had been a situation where something had gone wrong with their care or treatment.
- We were unaware of any investigations or resolutions that had taken place as a result of something going wrong within end of life care. The hospital did not inform us of any such incidents.
- Porters were not aware of any never events or serious incidents within the past year. They were aware of an incident where a patient was not wrapped correctly to be taken to the mortuary and they reported this to their line manager. The porters were not aware of any outcomes from this concern. They were able to describe how to report an incident and the process of how investigations occur. The porters did not use the electronic reporting system; instead, they reported any incidents to their line manager who then reported the incident to the hospital site manager. The estates department logged the complaints on to the electronic reporting system on their behalf.
- Therapies staff we spoke with said they were happy to report any incidents, and knew the process with the electronic reporting system, although once the concern

had been reported and acknowledged, no further communication or outcomes were given. This did not show the trust were sharing learning from the concerns or incidents that were reported. Staff felt this system was a tool to collect statistics rather than to resolve any issues that had arisen.

Cleanliness, infection control and hygiene

- The trust had a service level agreement with a contractor to provide domestic services. This included cleaning, portering services and waste management amongst other duties.
- All of the wards we visited were visibly clean and tidy, although some were in need of new decoration as they looked old and tired.
- We visited the mortuary based within the hospital and found a lack of infection control in the post mortem suite. We found sharps boxes open without their temporary lids closed, sharps buckets completely open with instruments sitting inside them; swabs, specimen pots and other supplies were out of date. During our inspection of the post mortem suite we found there was a crossover of the dirty utility and the clean utility. This was a breach of Health and Building Note 00.09 Infection Control in the built environment HBN 00.09 and the Hygiene Code. There was also a domestic fridge within the clean facility which was a further breach. When the fridge was opened, a strong odour came from it. We were advised the fridge was, at times, used for keeping specimens.
- The dirty utility also had finger taps on the sinks when they should be elbow opening taps for infection control purposes.
- All staff we observed throughout the hospital were bare below the elbows, washed their hands before and after seeing patients and used hand gel as appropriate.
- The mortuary equipment was visibly unclean, table tops, taps and worktops had grime and limescale visible. Aprons, hand wash and hand moisturiser were visible within the mortuary, however there were various sizes of gloves that had not been kept filled ready for use.
- The porters were trained in infection prevention and control techniques. They were responsible for cleaning the concealment trolley which was used for taking a deceased patient to the mortuary. They were aware of protocols and procedures for transporting a deceased patient to the mortuary including the use of body bags

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as appropriate. Porters were aware that the use of personal protective equipment such as gloves, aprons, alcohol gel and other infection prevention and control measures were required when dealing with patients and the deceased.

- An agency was responsible for deep cleaning the floor of the post mortem (PM) room every month, although mortuary staff were responsible for deep cleaning the PM tables and surfaces every month. The taps were run in the PM room every day to keep them free of microbes and to stop the build-up of bacteria. We found the PM room tables and taps to have limescale and build up on them. The taps were finger turning rather than elbow tabs, this is contrary to the hygiene code.
 - Within the post mortem (PM) room we identified a number of infection control issues. We found yellow sharps bins unlabelled and their temporary lids were not closed, large yellow clinical buckets containing large instruments did not have the lid in place or closed temporarily. We also found a blades sharps box that had not been labelled or dated at all. There were no spill kits available for bodily fluid spillages; specimen pots, swab collectors and stitches were out of date.
 - Within the ED viewing room, we found a commode and a carrier bag with a takeaway left within it. This is not in keeping with infection prevention and control.
 - The mortuary had been inspected by the Human Tissue Authority (HTA) two years prior to our inspection. They had made some recommendations and the department were able to show the changes they had made in response to these. There were no current action plans outstanding at the time of our inspection.
- concealment trolley was used. For bariatric patients, transport to the mortuary was via their hospital trolley bed rather than a concealment trolley; bariatric concealment trolleys were not available within the hospital.
 - We found that not all items of electrical equipment had been recently safety tested. Safety testing was last carried out within the mortuary during 2012. The only up to date items were the lights, fridges and electrical sockets, as these were tested under contract by an independent company.
 - The capacity of the mortuary was 32 fridge spaces and four deep freeze spaces. There was a separate fridge for babies and bariatric patients. If there was an issue with space, 'pop up' fridges were obtainable and placed within the post mortem room, although there was an agreement with an undertaker to remove deceased patients to their stores if space became a problem.
 - We were told the mortuary conducted tests on their fridge alarms every three months. If there was an issue with equipment, for example the fridges, the engineers attended on the same day to resolve the issue. The fridges were able to maintain their temperature for eight to 10 hours if the doors remained closed. The alarms were linked to the body mass storage system. If the alarms were set off, the security team alerted the mortuary staff, even out of hours. The temperatures of the fridges were recorded and monitored every day except at the weekend. We saw evidence of this process.
 - Within the emergency department there was a viewing room for relatives of patients that had died within the department. There was a cupboard situated within the viewing room on the wall that contained cleaning materials, however the cupboard door was not secure as one of the hinges was broken. This was dangerous as it could have fallen on to a person who may have entered the room and stood close to the cupboard. We notified housekeeping of the situation and this was rectified immediately. This viewing room led on to the emergency department (ED) relatives room.

Environment and equipment

- There were syringe drivers on every ward for palliative and end of life care patients. These were used for delivering measured doses of pain medication and were maintained by the equipment library. The Specialist Palliative Care Team SPCT carried out spot checks on the syringe drivers to ensure they were correctly maintained. The SPCT kept an extra syringe driver as spare for emergency purposes.
- The mortuary was well equipped, however there was only one concealment trolley available for use. A concealment trolley is a covered hospital bed used to transport a deceased patient from the ward to the mortuary. There were no spare trolleys in the event of equipment failure. For young children, the same

Medicines

- Syringe drivers were stored securely on all wards as well as spare ones for shared use throughout the hospital. Their use was recorded to ensure they were returned after use and available when needed.
- There were three wards within the hospital with nurses trained to set up and use the syringe drivers safely and

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appropriately. There were six nurses on AAU, five nurses on T3 and two nurses on T5 trained. Not all nurses had been trained to date. Correct documentation was used, including checks. We noted that all band 6 or above nurses on one ward were trained. A further training program was being rolled out by the palliative care team which had included approximately 70% of the nurses on another specific ward so far.

- Strong opioid injections were stored separately to reduce the chance of error and reversing agents were kept within the areas that the medications were in use. The regular pharmacy controlled drug audit was checked and we observed that this was maintained.
- Junior doctors were given support by the SPCT to prescribe medicines for palliative care patients. We saw evidence of anticipatory prescribing to support patients being discharged home.
- A junior doctor stated that they had to be very pro-active to get help from the specialist palliative care team (SPCT). A senior nurse said that the support from SPCT had improved recently with multidisciplinary team (MDT) attendance, however it was still more difficult to get help when it was not a cancer diagnosis. Consultants on elderly care wards had been seconded to the community palliative care team and supported the juniors in their prescribing.

Records

- The patient records reviewed were all paper records. We did not see evidence of electronic palliative care records. We were informed the hospital was piloting an electronic system to ensure good integrated out of hours care for patients that had returned to their homes.
- We reviewed 23 paper patient records during our inspection.
- Palliative care patients had a full Individualised Priorities for End of Life Care (iPELC) document within their patient notes. This document contained details for patient care during the last stages of life, including guidance for changes to the patients treatment as they deteriorated, or their status changed. Guidance for medications, nutrition and hydration through to patients wishes after death were within this document. The document also had spaces to record various patient wishes. The iPELC was introduced following the withdrawal of the Liverpool Care Pathway. The iPELC roll out was completed trust wide during August 2016.

- Separate documents for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and symptom relief charts for last days and hours of life were also used. These were found within the patient record.
- When the SPCT had been involved with a patients care, the comments, nursing notes and recommendations were documented within the patient record. The notes were clearly written, and advice was provided for the specialist team caring for the patient.
- The mortuary had devised recording systems and safeguards for the arrival of deceased patients. There was a porters' book that all porters used to record the time that they arrived within the mortuary with a deceased patient.
- There was also a mortuary register kept by the bereavement officers. This was to record the deceased patient, their departure from the hospital with the undertaker and various other details to ensure traceability and accuracy.
- The bereavement officers also worked within the mortuary. They told us about a situation where two patients with the same name and same month and year of birth had been brought into the mortuary at the same time. They explained the safeguards and steps taken to ensure the correct deceased patient was recorded, viewed, and removed correctly.
- The mortuary staff showed us that they retained a copy of all electronic complaints and concerns submitted to ensure they had a record of the issues they had raised.
- We were able to ask the mortuary staff to provide any document relevant to their department and they were able to tell us exactly where it was, show it to us or explain how they would request this. Everything was logged and recorded.

Safeguarding

- We saw records that showed two out of the three nursing members of the specialist palliative care team (SPCT) had completed their safeguarding adults and children training to level two, although there were no dates to state when this training had taken place. All the staff we engaged with were able to name the adult safeguarding lead for the trust and knew how to raise a concern. This included the chaplains within the hospital.

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- No safeguarding concerns were shared with us during the inspection. Staff were unable to give us examples of safeguarding referrals or concerns that they had raised. The chaplains had received training for safeguarding adults and children to level two.
- Although there was a tool box discussion for safeguarding, the porters were due to attend a full safeguarding training programme in the near future.

Mandatory training

- Junior doctors did not receive end of life care training during their induction, however this was completed by the end of their first month of employment. They attended two training sessions on end of life care annually.
- We asked for the SPCT clinical nurse specialists (CNSs) training records, however this was not provided in full. We found only two out of the three nurses had their training recorded on a database, and one of these nurses had completed all their mandatory training. There was no training record for the third CNS. There were no dates provided for any of the training, therefore we cannot confirm their training was up to date.
- All ward staff were provided with mortuary training as part of their induction. There was a team of three staff working within the mortuary conducting training. The ward staff were trained to ensure practices on the wards for the preparation of a deceased body were consistent across the trust. There were monthly meetings to discuss this training, and to see if any practices or protocols needed to be included or changed. There were links with the mortuary via the matrons from each ward.
- Porters were provided to the hospital via a contractor, however mortuary services training was conducted by the trust. The porters were unable to state how often they were provided with training, although they were aware they had received training during their induction. We asked to see the porters training records, however we were only provided with evidence of porter mortuary training. Further training was provided directly via the porters management team on a monthly basis. This system was known as 'tool box talks'. It was a discussion that the department engaged with around a specific topic, for example safeguarding. It was an A4 sheet of paper that contained relevant basic information on a specific topic to promote discussion.

- The porters had to undergo specific training for various tasks such as a medical gas training and blood sample collections. They were only allowed to carry out these tasks once they had completed their training. The porters had to attend all training courses as their duties were so variable. They had to be trained for all eventualities.
- The chaplains had completed all of their mandatory training. This was mainly completed online except for basic life support which was face to face.

Assessing and responding to patient risk

- We asked ward staff and the SPCT if there was an algorithm or identified system to trigger a referral to the SPCT. The staff said the doctors decided to refer patients based on discussions during multi-disciplinary meetings (MDTs). There were no specific triggers to referral. A potential reason for lack of referral to the SPCT was due to poor recognition of end of life patients.
- We saw National Early Warning Score (NEWS) documents were kept within patient records. They were used by staff to identify deterioration in a patient's condition. We also observed Waterlow (pressure ulcer risk assessment tool) charts and Malnutrition Universal Screening Tools (MUST tool) being used within patient records. All the charts that we observed within patient records were fully completed.
- We looked at 18 patients records and found prescribed care had not always been given. A patient was due to have hourly mouth care, however it was recorded within the patient notes that this had only occurred four times on one day, and once on the day that we visited. This was brought to the attention of the ward deputy manager. We were informed the patient would receive appropriate on going care in line with their care plan. During an unannounced visit to the same ward following the inspection, we found that the hourly prescribed care had still not been adhered to, however the number of interactions with the patient had greatly increased. This situation was brought to the attention of the doctor in charge of the patient, and they reassured us this care would be a priority and reinforced.

Nursing staffing

- The staffing levels were calculated by a ward matron using a nursing acuity tool. They calculated the need for 4.6 whole time equivalent (WTE) CNSs, however due to staff sickness or unavoidable absence cover they

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rounded this up to 5 WTE. The planned staffing of the SPCT was above the recommendation of the Royal College of Physician for the number of acute adult inpatient beds.

- During our initial inspection, the SPCT consisted of three clinical nurse specialists (CNS) and three part time consultants. The three CNS's worked full time Monday to Friday between 9am and 5pm. When we returned to the hospital two weeks later we found the nursing levels within the SPCT had changed. The acting lead nurse for the SPCT had retired and was on leave prior to returning to the department to work on a part time basis, three days per week (between Monday and Friday) whilst the vacancy for a new clinical nurse specialist (CNS) was advertised. We were assured the new vacancy was due to be written and advertised imminently. We also found, on the day we returned to the hospital for our unannounced visit, one of the SPCT CNS staff was off sick. This meant there was only one CNS available for the hospital until the other CNS returned from sick leave. However, this CNS was actively supported by three palliative care consultants on that day.
- Outside of office hours, during weekends and bank holidays there was no SPCT cover at all. No bank or agency staff were used when SPCT CNS staff were not available. During staff sickness or absence there was no cover for the CNS. A fourth full time CNS was due to start working with the SPCT at the end of October 2016, however two of the five working days will be protected time for delivery of end of life care training to the trust.
- There were no health care assistants attached to the nursing staff within the SPCT.

Medical staffing

- There were two palliative care consultants based within the hospital palliative care team. They worked part time Monday to Friday, 9am to 5pm. A further palliative care consultant who worked in the community, attended for an in-reach session (0.1 WTE) on a Wednesday morning to improve integration of care for patients on discharge. The total consultant cover was 1 WTE.
- The 1 WTE was shared between the three consultants, (one covering 0.5 WTE, one covering 0.4 WTE and one covering 0.1 WTE.) All consultants were available for the SPCT weekly multidisciplinary meeting (MDT) on a Wednesday morning, although during our inspection only two of the three consultants attended.

- There was no out of hours provision for consultant cover outside of normal working hours. The trust did not provide seven day, 9am until 5pm, face to face consultant cover as set out in NICE guidelines for end of life care staffing.
- There was no use of locum cover for palliative care consultants. There was no cover provided if a consultant was off sick.
- We asked ward staff and doctors what they would do if they had needed to speak to a palliative care consultant outside of their working hours. We were told staff contacted the medical or oncology consultants for advice.

Major incident awareness and training

- The trust were able to provide details as to how the mortuary would be used if there was a major incident. They were also able to provide details of additional body storage in the form of 'pop up fridges' and alternative arrangements with the public mortuary.
- The mortuary stated they had a large store of equipment available should there be a major incident.
- Mortuary staff were aware of their roles and responsibilities should there be a major incident. They had a checklist to act as a prompt and to assist with their duties.

Are end of life care services effective?

Requires improvement 

We rated effective as requires improvement because:

- There was no out of hours cover for the SPCT. The SPCT only provided a palliative and end of life care service Monday to Friday between 9am and 5pm. This was not compliant with NICE guidelines.
- We found DNACPR documents had been completed without patient involvement due to lack of capacity. We noted, against trust policy, mental capacity assessments were not always completed.
- All wards had an EoLC champion although when they were absent there was no one to cover the position.
- The SPCT produced a pocket guide for ward staff and doctors to follow outside of normal SPCT working hours. We found not all doctors were aware of this document,

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there was no copy of the document within the palliative care folders on wards or on their notice boards; those that were aware of the pocket guide said they did not have a copy of it or had not seen it.

- The trust did not meet the set key performance indicators (KPIs) for the '5 priorities of care for the dying patient'. They performed below the national England average.
- Trust audits showed they were poor at recognising patients that were entering the end stages of their life.
- The trust audited discussions with patients and their relatives regarding care plans; the audit results for 'do not attempt cardiopulmonary resuscitation' (DNACPR) discussions showed a lack of recorded discussions or that the discussions failed to take place at all. Therefore patient needs were not always being met.
- The input of the therapies teams at the MDT was not always respected. The therapies team felt they were under pressure to discharge patients too quickly even when this was not appropriate or safe for the patient or their families. They also found that some consultants were not always willing to involve them with their patients care.

However:

- Patients said their pain was managed quickly and appropriately.
- A minimum of 50% of registered nurses on all wards had been given training by the SPCT in palliative and end of life care. This was the trust target.

Evidence-based care and treatment

- There was a minimum of one end of life care champion on each ward. The staff we spoke with on wards, including matrons, told us all palliative care or end of life care patients on their ward would be referred to the SPCT. They were not to be managed on the ward without their input. We spoke to the SPCT who disagreed with this comment. They stated they were not always informed of every palliative care patient within the hospital as it was not always necessary for them to be involved. They felt this would have been a failing on their part as it would have meant the training and resources they had provided were ineffective. They also felt as they were such a small team, this would not have been practicable. At the time of our inspection, there were 17 palliative and end of life care patients within the

hospital that the SPCT were aware of. We only found one patient within the hospital during our inspection that was classified as end of life by their medical team, who had not been referred to the SPCT.

- The trust had designed a form to be used for palliative and end of life care patients called an iPELC in response to the withdrawal of the Liverpool Care Pathway. All of the patients we visited who were palliative or end of life care patients had this form within their patient record, however it had not always been filled out completely or correctly by nursing staff.
- The trust were aware they had performed worse than the national average for the key performance indicators (KPI) set out in the 5 priorities of care for the dying patient.
- In 76% of cases, the trust had recognised and documented the patient had entered the dying phase. The national average was 83%.
- For 71% of patients, a documented discussion had occurred with the family or next of kin. The national average was 79%.
- In 40% of cases a documented holistic assessment of the patients' needs was carried out and documented. The national average was 66%.
- The trust told us their target for all KPIs was 80%. They were honest in their discussions about the audit and were actively looking to improve their processes to achieve their target, although they were aware this is a process that may take time to achieve. There was an action plan in place, however they were experiencing financial constraints which were hindering the process.
- The National Care of the Dying Audit 2016 (NCD) was carried out by the trust. They achieved two out of the 10 KPIs. These were for training staff in communication skills for care in the last hours or days of life and patients concerns being listened to. They did not achieve the remaining eight KPIs. They had not provided a bereaved carers survey since 2013 therefore benchmarking against other providers of a similar service was not possible.

Pain relief

- All the patients we spoke with during the inspection told us their pain was appropriately controlled. This was evidenced within their patient records. There was no dedicated pain relief CNS attached to the SPCT.

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- Pain management was carried out in line with the iPELC document which contained a flow chart and advice to the clinician. It stated appropriate medications and dosages required to control symptoms.
- All patients had a symptom control sheet within their patient record when they reached last days and hours of life. All the symptom control sheets we reviewed were appropriately completed. The forms ensured consistent patient care and various assessments for symptoms including pain were carried out at least every four hours.
- Pain relief was given quickly and efficiently when requested by patients.

Nutrition and hydration

- All patients were screened on admission using the MUST (malnutrition universal screening tool). This was a tool used to establish the nutritional status of a patient.
- Patients had feeding charts within their patient record cards as well as fluid input and output charts. The records we checked were all completed and up to date.
- Where a patient particularly wanted something specific to eat, there was an option to speak with the catering manager to see if this was a possibility, however there was no chef on site making options limited.
- Although the patient's family were able to bring food in to the hospital there were no facilities for patients or their relatives to be able to heat food.
- For patients living with dementia or learning difficulties, their food was served on a red tray. This was an indication to ward staff the patient required longer to eat their food, or they may have required extra assistance to help them eat. There was no finger food menu for patients at the time of the inspection, however options were under discussion.
- The trust dietitians were available to the SPCT if required, however it was generally the patients consultant that would involve them if they felt it was appropriate.
- The dietetics department were available to give advice to the patient, their relatives and the specialist team on nutrition and fluid intake at the end stages of life. They worked closely with the speech and language therapists as they completed various assessments to check the patients ability to eat food and drink safely.
- There were concerns raised by some therapists that some consultants did not like to involve speech and language therapist in the patients care. This was because they believed the speech and language

therapists would automatically state the patient had to be nil by mouth during palliative or end of life care. They found this misconception very disappointing and at times challenging to work with.

- Advice and guidance on nutrition and hydration was available for palliative and end of life care patients including those that were nil by mouth. Some patients were being PEG fed or fed via a naso gastric tube (NG tube). Dietary requirements were maintained for religious and cultural beliefs as well as for patient preferences including vegetarian and lactose free options. All the Ng feeding options were halal and kosher.
- Dietitians were available to see end of life care patients and tailored their advice to the specific needs of the patient. If they required extra meals or snacks, these could be arranged.

Patient outcomes

- The trust carried out an audit between March 2015 and April 2015 of 102 patients who had died whilst at the hospital. There were exclusions to this audit, for example overdoses. The trust used the 'One Chance to Get It Right' model as the Liverpool Care Pathway had been withdrawn. The audit looked at various indicators; these included communication, provision of information and holistic care.
- This audit identified the most common cause of death was pneumonia in just over 50% of cases. Of those who had died, 67% of patients were recognised as approaching end of life and had documentation completed, however 33% of patients had no documentation.
- Communication with the patient approaching end of life was low at 80%, however 63% of the families were informed the patient was approaching end of life. This was documented within the patient notes.
- Just over 50% of patients had documentation within their patient records for physical care plans, 13% for psychological symptoms and 13% for spiritual symptoms. 23% had their social situation documented within their care plan and 22% had their preferred place of care recorded. Only 27% had their hydration and nutritional preferences recorded.
- This audit showed the trust were able to identify 67% of patients approaching the end of their life. However, the percentage of patients with documentation of their individual needs and preferences was very low. The

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hospital felt the reason for the low scores was because the patient was either drowsy or too unwell for conversations with staff regarding their needs. The trust recognised patients were not receiving a complete and thorough end of life care assessment and identified steps requiring improvement.

- The leads for end of life care within the trust were aware of areas for improvement. They understood they needed to send out the bereaved carers questionnaire, therefore they would have been able to benchmark their service against others. This had not been used as the hospital were awaiting approval from other trusts before the survey could be sent out. There was a requirement for the same survey to be used across a number of trusts to ensure there was a direct comparison between the service provided.
- NICE guidelines stated there should have been a seven day, face to face palliative care provision Monday to Sunday, between 9am and 5pm with an out of hours service provided. The service was working towards providing this standard and had put forward a business plan to try to secure the funding. Unfortunately, the request was put on hold for review at a later date. We asked the trust to provide timescales for the review but they were unable to provide this.

Competent staff

- At the time of our inspection, the palliative care team comprised three part time (1 WTE) consultants and 3 WTE CNSs. When we returned to complete an unannounced inspection, we found the lead CNS for the SPCT had retired. A fourth CNS had been appointed and was due to start at the trust by the end of October 2016. The fourth CNS position was for 5 days per week- three days patient facing and two days staff training throughout the hospital. The trust were committed to finding the right person to fill the post and therefore were taking a short while to rewrite the job description. This was to take into account changes they wished to make.
- An appraisal audit showed that 91.67% of SPCT staff had attended and completed an appraisal within the past year.
- The SPCT attended various wards to review patients and offer specialist advice to hospital staff, the patient and their relatives. During their time on the wards the CNS showed the ward nurse how she was caring for the patient. The CNS also explained the treatment she gave to the patient so that a form of training was taking place for ward staff. All ward staff felt the SPCT CNSs were valuable and helpful and provided support to the ward as well as the patient.
- The SPCT organised a number of training days as well as some training sessions lasting an hour (some over lunch breaks) to try and encompass a wide staff skill set. Junior doctors were given end of life training as part of their induction. A number of colorectal surgeons requested end of life care training with the palliative care consultant. The SPCT found this a positive step with the consultants and showed specialities within the hospital had started to accept the benefit of a palliative care team. Unfortunately, some of the training sessions were cancelled due to the low number of attendees. Staff found it challenging to attend these sessions as their departments were short staffed and they were not released from duties to attend.
- Some of the improvements the trust felt necessary were further training within end of life care, and conversations with patients and their relatives to be documented. This would have been best practice.
- We were told junior doctors did not rotate through palliative care. The only EoLC training they received was between once and twice a year with the SPCT. Medications, dosages and forms of delivery were discussed, however there was no practical training.
- We spoke to 18 doctors and 17 nurses during our inspection and only two were aware of a palliative care pocket guide produced by the SPCT for use outside of working hours. This was to provide guidance for the palliative or end of life care patient. Each ward had a palliative care folder available for use by ward staff. The folder did not contain the SPCT pocket guide to palliative and end of life care. Most consultants, doctors and nurses were not aware of the SPCT pocket guide. Those that knew of the pocket guide said they knew it existed, however they had not seen it.
- The SPCT had managed to train at least 50% of all registered nurses on each ward, in palliative and end of life care. This was their target. They were looking at ways to increase this figure. They hoped to roll out further training to ward staff as well as doctors and consultants in the near future. However the current training rates compared favourably to other London acute hospital in data the trust used to benchmark the uptake of specialist palliative care training. In addition, the trust surveyed all staff who had received the training before

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and immediately after to determine the effectiveness of the training. The questionnaire was again repeated three to eight months following the training to assess medium term sustainability of the learned material.

- A barrier to the SPCT was staffing levels remained an issue. The SPCT was about to gain a fourth CNS at the end of November 2016, who will be responsible for EoLC training. We reviewed syringe driver training records and found three wards had no staff trained. The wards were Michael Bates, ASU and AAU. Other wards had varied numbers of syringe driver trained nursing staff.
- The hospital had a number of non-medical prescribers registered with the pharmacy department, however none of the SPCT were registered to provide this service. The non-medical prescribers policy was up to date.
- Verification of death was only completed by trained and qualified doctors. The trust had been unable to provide training for other staff, therefore the policy stated this was only to be completed by a doctor.
- Within the mortuary department, there were three members of staff, one of which was the mortuary manager. The two staff responsible for the mortuary were also the bereavement officers. They trained the porters in mortuary policies and procedures and made sure they understood the paperwork, mortuary register and the porters book.
- The porters were fully aware of process to safely and respectfully remove a deceased patient from the ward and how to store the body appropriately, maintaining dignity and respect at all times.
- The SPCT conducted teaching sessions every Thursday morning for junior doctors with the medical director. Symptoms and their control were discussed, as well as links to palliative care within the community. During the training sessions, junior staff were given pocket guides to assist with decision making. Oncology and medical registrars were also given pocket guides and training to assist their knowledge. This information was also available on the hospital intranet.
- A nearby hospice provided free training events for staff on occasional afternoons. Staff were released from their duties to attend these sessions.
- The chaplains attended courses outside of the hospital. They were given time to be able to undertake the courses. This was specific chaplain training.
- All bereavement officers were due to have their appraisals at the beginning of October, these were booked. The team had completed their mandatory

training via e-learning modules except for those that required face to face training, for example, basic life support. The bereavement officers, where possible would attend the coroners court once or twice a year to hear a case as part of their learning and ongoing training. They also attended any training courses giving updates on any legislative changes. These courses were generally run outside of the hospital.

- The SPCT were given regular supervision by the hospital psychologist on a monthly basis to ensure their health and well-being.

Multidisciplinary working

- The SPCT attended multidisciplinary team meetings (MDTs) within the hospital on a Wednesday. They used these meetings to get an update on patients within wards and to obtain new referrals. During the meeting, we observed full discussions regarding each patient including their physical symptoms, spiritual needs, DNACPR status and any discharge plans.
- Within the oncology and haematology MDT there was a very heavy emphasis on patient discharge. Some members of the MDT were put under pressure by the lead consultant to agree discharge. They stated their case clearly and ensured their point of view was heard and taken into consideration, leading to reconsideration of the decision.
- The general MDT was well attended by consultants from various specialities, the therapies departments which included dietics, speech and language therapists, physiotherapists and occupational therapists. The chaplains and a social worker were also present.
- The SPCT worked with the community palliative care team and had good contacts outside of the hospital. There was a system in place known as Palle8. This was a group of consultants and CNSs that worked within hospitals, hospices and the community as a reference group. The SPCT was a member of Palle8, the expert reference group for Palliative Care providers within North Central London. With some other members of the Palle8 group they were developing options for a regional consultant on-call rota. We were told the issues preventing the trust from providing a full 7-day service were lack of funding from the trust to provide 1.5 WTE increased staffing for CNS. Palle8 was working towards

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a seven day a week consultant on-call service with out of hours telephone cover, covering several hospitals in the PALLE8 catchment area (Northeast and North Central London).

- Each ward had an end of life care champion. This designated nurse was the main contact between the SPCT and the ward. They were there to support their colleagues with any EoLC questions or to help with new equipment. When the ward champion was off sick or on leave there was no cover. The champion we spoke with during the inspection said since the iPELC had been rolled out across the trust, everyone had been trained by the SPCT, therefore the demand for EoLC champions on the wards had reduced.
- Referrals to the SPCT were made, in general, at the multi-disciplinary team meetings (MDT). Each speciality consultant was given the opportunity to discuss their patient list. The chaplains were also a good source of referrals for the SPCT as poorly patients may seek religious or spiritual advice and comfort.
- The therapies team were visible around the hospital, however they did not get very involved with the SPCT. The physiotherapy department felt their involvement was normally for disability management and rehabilitation, or to keep patients for transplant purposes in a viable condition. By providing exercises and movement for the patient, the team were able to keep the lungs clear so that they could be used for transplant purposes.
- The team were also actively available to assist patients in need of disability management, were at risk of pressure sores or had poor skin integrity. The team stated they did not really have much involvement with the palliative care team. Once the patient was classified as end of life, they felt medication was more appropriate and longer lasting than exercises or stretching. Occupational therapists (OTs) told us they did not really get very involved with end of life care patients either. They only became involved with the patient if any adaptations were needed within the patients home, once they were ready for discharge. We also found they had different interpretations on the terminology and timescale for end of life care patients. There was no other involvement from the OTs for end of life patients. OTs felt under pressure to move or discharge patients as quickly as possible; at times they felt this was inappropriate.
- Speech and language therapists (SLT) were more involved with end of life care patients. They were involved in swallowing assessments which assisted in decision making for a patients feeding status. They could give advice to the medical team and recommend the patient to be nil by mouth or able to eat and drink. This team were actively trying to build links with the SPCT and build pathways for better and closer working relationships. The SLTs felt the SPCT focused on the comfort of the patient and their wants and needs, giving patient centred care, however they said there was room for further involvement. The SLTs were able to prescribe mouth care, food for flavour (where the patient was able to taste the flavour of food but was not put at risk of choking) and conduct other forms of assessment. The SLTs were working to try to change the mind-set of certain staff but it was a slow process and was ongoing.
- A further frustration for SLTs was the high turnover of staff within the wards. They trained staff to assist patients with certain feeding requirements, however they found staff left very shortly after. This meant new staff had to be shown how to feed patients and this was time consuming.
- Dietitians attended the general MDT every Wednesday, however they did not attend the SPCT MDT. They obtained palliative care referrals via bleep, over the telephone or face to face from the SPCT or the patients' medical team.
- There was no social worker linked to the SPCT, however they said this would be ideal and is on their wish list. Due to financial constraints the SPCT said this was very unlikely as it was not a priority. A social worker would have been an important part of the discharge team to assist the patient returning home.
- Within the hospital there was a MacMillan stand and a Helen Rollason support centre. The Macmillan cancer information manager said they did not really have many conversation about end of life care with patients or their relatives, however the leaflets and booklets provided were taken. The Helen Rollason support centre provided counselling and support groups. Both charities assisted and interacted with the SPCT as much as possible.

Seven-day services

- The trust provided a face to face palliative care service on a Monday to Friday basis, between the hours of 9am and 5pm. There was no palliative care consultant or CNS cover outside of these days and times. The NICE

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guidelines state there should be seven day a week face to face consultant cover, between the hours of 9am and 5pm. The trust were working towards providing this service by submitting a business case to the Board for a fifth CNS, however at the time of our inspection the request had been unsuccessful and was awaiting review. No timescales were available for this request.

- The trust did not provide seven day a week face-to-face access to the SPCT, between the hours of 9am and 5pm, although 37% of the national average had achieved this KPI. The hospital also did not provide an end of life care facilitator for the trust, 59% of the national average had achieved this KPI.
- Had there been an urgent need for palliative care consultant advice or assessment, the ward staff had been told to contact the medical or oncology consultant on call for advice. There was also advice on the hospital intranet and a palliative care folder available in all clinical spaces. Some doctors were provided with a pocket guide with advice on symptom control for palliative care patients. The iPELC document provided for all palliative and end of life care patients was also a source of information and guidance.
- The chaplaincy service was available 24 hours a day, seven days a week, 365 days a year. Out of hours chaplaincy was available for many faiths, however there could be a two hour wait for the arrival of the appropriate faith leader.
- The mortuary opening hours were Monday to Friday 9am until 3.30pm for viewings, however there was flexibility to assist relatives and friends outside of these hours. There was sensitivity around the collection of deceased patients that had to be removed at short notice for religious and cultural reasons. The porters were trained to be able to provide an out of hours service for viewings, undertaker collections and removal of deceased patients to the mortuary. Only the porters help desk coordinator was able to conduct viewings outside of normal hours due to receiving further training.
- Medical Certificate Confirming Death (MCCD) was issued as soon as possible. If the death occurred outside of normal working hours, the certificate was ready by 12pm the following day where possible. This could be dependent on the availability of the doctor or consultant the patients care fell under.

- The trust were part of an electronic patient record system. This was a scheme to record medical information supplied by a patient within an electronic record. The emergency services, out of hours GP's and other healthcare professionals were able to view the information. This helped ensure the patients' preferences and wishes were met with their future care; for example which hospital the patient may like to receive care and treatment from, or what the patient would like to happen in the event of a change in their medical condition. This scheme was not to be confused with advanced care planning that took place in some hospitals.
- GPs were involved with the patient care for rapid discharge. The hospital notified the GP to assist with arranging district nurse visits and care within the community for the patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a combined Mental Capacity and Deprivation of Liberty (DoLs) Safeguards policy written and based on the Mental Capacity Act 2005. The policy set out staff roles, responsibilities and actions to be taken if it was suspected that a patient lacked capacity or fell under the deprivation of liberty category. This policy also covered considerations such as advanced decisions, best interest decisions, independent mental capacity advocate service (IMCAS) and so on. The policy was up to date and due for review in March 2017.
- The Mental Capacity and Deprivation of Liberty (DoLs) Safeguards policy contained best interest checklists, mental capacity assessment and a best interest decision form, mental capacity assessment and best interest decision tool as well as a patient safety assessment tool for deprivation of liberty patients.
- We looked at 18 Do Not Attempt Cardiopulmonary Resuscitation (DNACPRs) orders and found that only eight were completed in full and correctly.
- We reviewed seven DNACPRs showing the patients lacked capacity. The decision were made in the best interests of the patient, however five DNACPRs did not have a mental capacity assessment completed to evidence the patients lack of capacity. The trust policy stated 'If a patient is deemed not to have capacity, or if there is any doubt as to their capacity, then a 2-stage assessment of capacity MUST be carried out (in according with trust policy) using the Trust's standard

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Capacity Assessment tool. The outcome of the capacity assessment must be recorded in the appropriate section of the TEP form.' Therefore it did not appear this policy was being followed in all cases. Staff told us one of the reasons for not completing the mental capacity form was given as 'the patient was drowsy'.

- Another DNACPR we reviewed stated the patient did have capacity, however the consultant did not discuss the document or status with the patient. They did however, speak to the relatives.
- We found four DNACPRs did not show a conversation had taken place with the next of kin or their relatives, before a decision had been made as to whether to resuscitate the patient if they had a cardiac arrest.
- An audit of DNACPRs by the trust during August 2015 showed 378 patient records were reviewed. Out of these patient records, 19% were found to have a DNACPR in place, 59% were signed by the patients consultant, 63% showed a discussion had taken place with a relative or friend, 24% indicated the decision had been discussed with the patient and in 11% of cases a discussion was held with the patient and their family or relatives.
- A further audit was undertaken during February 2016. This showed 394 sets of notes had been reviewed. Of the notes reviewed 24.3% had a DNACPR in place, 8.3% were time limited with 76.1% being indefinite orders. They found 9.5% had no review date or indefinite order comment on the document and 6.2% were being reviewed on the day of the audit. Nine per cent of records showed that no discussion had taken place with the patient or their next of kin.
- The same audit took place in August 2016 took place and 417 sets of notes were reviewed. From these records the hospital found 19% of DNACPRs were in place, 48% had a written date for review, 19% had been reviewed but not documented in the patient notes. They also found 61% of the reviews carried out were documented in the patient notes, 63% were signed by the patients consultant, 56% documented a discussion had occurred with the relatives or the patients carer, 34% of decisions were discussed with the patient, however only seven per cent of discussions occurred with both the patient and their relatives. A further finding of the audit was 10% of DNACPRs were signed in the best interests of the patient, however this was without a discussion with the patient, relative or their carer. This was an item listed on the hospital action plan as it was against hospital policy, however it was not placed on the hospital risk register.

- The trust reviewed their DNACPR audit twice a year and created an action plan from each. Although there were outstanding issues from each of the audits, the hospital recognised these areas for improvement, and had these as ongoing concerns within their action plan.
- The audits produced by the trust showed inconsistency of measurable outcomes. Each audit included different comparisons to the last. This made it difficult to see how the trust results improved or deteriorated, however, of the few consistent measures within the audit, the trust showed worse results and lack of learning. The trust also did not make it clear within their patient record sample as to whether all the patients should have had a DNACPR or whether these were random samples of patient notes from throughout the hospital, rather than just palliative or end of life care patients.

Are end of life care services caring?

Requires improvement 

We rated caring as requires improvement because:

- Staff did not always respond to call bells promptly except on Podium 1.
- Not all patients or their relatives were aware of the patients care or treatment plans. They were also not aware of future plans for discharge or transfer to a hospice.
- Prescribed care was not always provided to patients. We saw a patient that should have had hourly mouth care. This had not been regularly provided as set out in the care plan. We witnessed this on two separate occasions with the same patient.
- The bereaved relatives survey had not been sent out to families since 2013, even though it had been available for the past year. Therefore the hospital was unable to get a clear feedback of the standard of care they were providing to their patients. This also meant the trust was unable to benchmark itself against other providers.
- Some relatives that we spoke with told us that they felt they had to stay over at the hospital with the patient as they didn't feel the patients received all the care and attention they required as the staff were busy. Relatives that stayed at the hospital did not have any facilities

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available to them unless the patient was on Podium 1, in which case they were provided with a camp bed. On other wards the relatives slept on chairs next to the patient.

- Once the initial holistic assessment had taken place by the SPCT, there was no counselling support offered to patients. If they required this service, they had to request referral and wait to be accepted and seen by the psychologist.

However:

- Patients said they found the SPCT caring although they did not have much time they could spend talking to each of them.
- Visitors were welcome outside of normal visiting hours for palliative and end of life care patients.
- Bereavement officers were very caring and helpful towards bereaved families and went the extra mile to assist by making appointments for the relatives with the authorities to register the death of a loved one.

Compassionate care

- We found the SPCT team members very caring and helpful to the patients they visited and treated however they had limited resources; as a result staff often felt overworked. When we returned to the hospital for an unannounced visit, a CNS had retired and another was off sick, therefore only one CNS was left to work through the team's caseload alone.
- The patients we spoke with provided mixed reviews of the care they received from the trust. Patients felt the nursing staff were very kind and caring in general, however they did not have much time to spend with each individual. Some patients would have liked the staff to have had more time to speak to them, although they acknowledged they were very busy. They found the call bell was not always answered quickly but this was dependent on the ward the patient was in. Patients told us staff on podium wards tended to answer the call bells quicker than others.
- The majority of patients we spoke with were very happy with the level of pain relief given. They felt able to tell staff if they were in pain.
- Although each ward had certain visiting hours, palliative and end of life care patients were normally allowed relatives to visit outside of these times.

- Not all patients or their relatives were aware of their care plan or future thoughts or decisions, although there were patients who said the doctor had their treatment and medication to them.
- We did find a number of relatives concerned with the level of care their relatives received. We were told of a patient who was very vocal (the patient was unable to verbally communicate) and despite this staff had ignored the patient. The relative was upset and concerned that the patient was in pain because his catheter bag had not been emptied. Staff had not come to see if the patient required any help or assistance.
- We observed a patient that was nil by mouth; they had been prescribed hourly mouth care. We checked within their notes and found the patient had only received mouth care four times a day. The patient's mouth looked very dry and their lips were cracked. We spoke to the deputy ward manager about the care we observed. We were informed the care plan was incorrect. We were assured this situation would be rectified. We conducted an unannounced inspection just over a week later and found the care the patient had received had improved.
- The hospital had created a bereaved relatives survey approximately a year prior to our inspection, however they had not sent these out. We were told the survey had not been sent out as the trust were working with other hospitals delivering end of life care on this project, and needed to have their survey approved. They had hoped to use this survey to benchmark the care they provided against the other trusts. We were informed during our inspection that the survey was going to be sent out approximately two weeks later.
- The bereavement officers were very happy to assist relatives and friends. They made appointments for relatives with the local registration offices on their behalf. This helped elderly patients especially, as some found the system difficult to understand.
- The chaplaincy was available to all patients. Outside of normal working hours there was an on call service. The chaplains were able to be contacted via the hospital switchboard.
- There was a quiet room on Podium 1, however this was quite hectic. There were tea and coffee available for relatives within this area, however this was not the case on other wards. There was also a fridge where patients could store their food, and milk for tea. Within this ward, relatives staying with patients were offered food and drink from the patient trolley where possible.

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Understanding and involvement of patients and those close to them

- We spoke to 18 patients and six relatives and found responses varied as to how involved they felt in they or their loved one's care.
- Advanced care planning was a concern for the trust. During 2016 the trust audited advanced care planning. They admitted they did not do this very well and needed to improve. 44% of patients accepted the process, 31% were not offered the service, 24% were given advice only and 1% were imminently dying therefore the service was not applicable. They felt many palliative and end of life care patients were seen too late to enable a plan to be put in place. The SPCT started a continuing EoLC training programme, covering advanced care planning, communication and recognition of the dying phase as key subjects. They also introduced an individualised EoLC document (iPELC - individualised Priorities for End of Life Care) to guide those discussions.
- Organ donation was placed on the iPELC as part of the advanced care planning and decision making tool. If a patient or their family requested to donate organs, the organ donation CNS would have been contacted. The team were unable to identify any instances where this had occurred.
- The bereavement care policy had recently been reviewed and was in date, however the appendices had not been updated. They remained dated at 2012, although they were due for yearly review.
- The hospital, where possible moved dying patients into a side room if requested by the patient, however this was not always possible. Infection control concerns took priority; patients that were a risk to the wards had to be placed within these side rooms.
- A relative we spoke with felt they had to stay with the patient due to concerns with the level of care and attention the patient required. The relative slept on a chair next to the patient. They had to move the patient in their bed to help them get comfortable without any assistance quite often and they found this difficult.
- Some religions required the deceased body to be released very soon after death. The hospital were able to accommodate this request and would always ensure there was someone available to release the deceased patient to the funeral directors. The trust was not able to support families conducting overnight vigils due to staffing arrangements and safety, however the hospital

was happy to accommodate the relatives by making provisions for them to be remain with their loved one for approximately 30 minutes within the mortuary. They tried to ensure the mandatory paperwork was completed as soon as possible so the deceased could be released very quickly. If there was space, the ward may have been able to accommodate the relatives overnight to conduct a vigil.

Emotional support

- The CNSs within the SPCT had been trained to provide a level of emotional support and counselling to their patients. There was limited availability for patients to be seen by the clinical psychologist. There was very limited counselling services available for patients. One patient we spoke with told us they had seen the psychologist once. They were then informed to request further sessions if required. There was no ongoing support for patients unless they specifically requested assistance. Not all patients were aware of the availability of counselling services.
- Most patients that spoke with us during the inspection had not received any counselling and had not been offered this service. One patient had requested counselling but was waiting to hear further from the hospital.
- The SPCT were given clinical supervision once a month by the clinical psychologist. The SPCT had 'down time' on a Friday afternoon which included ad hoc reflection time for the staff to share experiences. Schwartz rounds were provided within the trust; the SPCT attended these sessions. They covered end of life issues amongst other clinical and non-clinical subjects. Schwartz rounds were used to allow staff from many different areas within the hospital to discuss and share their experiences with colleagues.
- During the initial holistic assessment by the SPCT, patients were assessed for anxiety and depression. There was no further assessment for these patients. Staff told us that the resources were not available.
- Leaflets were available for the patient, relatives and their friends to help them understand the process of dying and what to expect.
- We were told weddings and blessings were able to be arranged for patients within the hospital at very short notice. There were good links with the community to help arrange religious ceremonies as required. Bedside services were a large part of the chaplains work. They

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attended patients when they were alerted by the ward or the SPCT. For patients that had no relatives or friends they attended the patient as often as possible and tried to get to see the patient every day.

- New patients seen by the chaplaincy via their ward rounds, referrals from the wards and the SPCT.
- A CNS went to visit a patient during our inspection, however the patient had died. She spent considerable time talking to the relatives and offering support to them at a very difficult time.
- The chaplaincy was available to staff as well as patients. They were involved with debriefings in complex or particularly difficult cases, or if there had been a traumatic incident. They were able to offer emotional and spiritual support for all those involved, however they did not receive clinical supervision themselves.

Are end of life care services responsive?

Requires improvement



We rated responsive as requires improvement because:

- The SPCT were not aware of all palliative or end of life care patients within the hospital. The team may have been able to provide advice or assistance to patients and their medical team to ensure they had appropriate care and their needs met.
- Parking permits were provided to patients relatives at the discretion of the ward, therefore there were inconsistencies across the trust.
- We were unable to establish accurate figures for patients that achieved their preferred place of death as the hospital audit had been recorded incorrectly.
- There was a lack of facilities for relatives to be able to stay with patients placed in wards outside of Podium 1.
- The trust had not completed advanced care planning in adequate time for many of their patients. Many of their patients did not have the opportunity to produce an advanced care plan as this process was not always offered to patients.
- The trust showed they had not taken learning from complaints and concerns raised as feedback had not been given to those who had raised the concerns and the type of incident was repeated a number of times.

However:

- The SPCT were proactive with rapid discharge of palliative and end of life care patients.

Service planning and delivery to meet the needs of local people

- From April 2015 through to March 2016 the SPCT received 707 referrals, of these 367 were cancer related, 159 non cancer related, 26 had no diagnosis recorded. The rest of the referrals were new or re-referrals to the team. The SPCT felt their referral rate had increased as a result of Chase Farm Hospital accident and emergency department having been downgraded. This resulted in an increase in admissions at the trust.
- The SPCT recognised they did not get to see all the patients they felt would benefit from their care, however this was a work in progress and they were looking at ways to improve their availability to those that required their expertise and advice.
- Some relatives were given free parking within the hospital whilst they were with the patient, however others did not have this experience. There was a leaflet called the Carers Passport Scheme. It described how the ward could issue a badge to the carer of a vulnerable patient to enable the relative to see the patient outside of visiting hours, assist the patient during mealtimes and help the patient with their personal care. Within the leaflet, it detailed a carers overnight rest room facility, however there were no relatives or carers rest rooms at the time of our inspection. Passes were issued at the ward staffs discretion. Within this leaflet, there were names, addresses and telephone numbers of other organisations that may be of assistance to the carer and the patient. This was a general leaflet aimed more towards those patients with learning difficulties or dementia rather than for end of life patients.
- The mortuary viewing room had neutral decoration and contained no religious symbols or icons, however these were available on request. There were prayer books available for a multitude of religions within the viewing room and there was plenty of seating around the outside of the room.
- The Individual Priorities for End of Life Care (iPELC) programme was rolled out across the whole trust from February to August 2016. This was accompanied by a training programme aimed at medical, nursing and Allied Health professionals.

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- The trust recognised the need to further develop the SPCT and we saw evidence the investment in SPCT had increased by 43% since 2014.

Meeting people's individual needs

- Advanced care planning was an area the trust felt it needed to improve. Palliative care patients were encouraged to plan their future wishes in advance, such as their treatment options and where they preferred to be cared for and eventually die. The SPCT were instrumental in providing training to staff to help initiate this conversation with the patient and their loved ones in good time, to enable the patient the opportunity to make their own decisions with as much information and support as possible.
- Around half of patients we spoke with said their relatives were not always offered refreshments when visiting them. The majority of patients said they didn't like the food or the choices they were given. Some said they only ate the food provided by the hospital as they had to eat.
- Patients found the food menu boring and disliked it. We did not hear any positive comments about the menu or selection of food available. There was no chef onsite therefore choices were very limited.
- The hospital had a system to assist patients with learning disabilities or those patients requiring extra help and time with tasks. There was also a system in place for those who needed help to understand information they were provided with. The document used for this purpose was the hospital passport and purple folder. We only found one patient record that contained an insert sheet to state the patient had a learning disability. This contained a purple flower.
- We were shown a copy of a sheet used within patient records for patients with learning difficulties or dementia. This was a simple form that indicated the name the patient liked to be called, what help they may have needed and their hobbies or interest, including foods that they liked and disliked. During our inspection, we only found one of these forms completed within a patient record, although there were other patients with dementia that we observed who did not have this document within their record. On the care of the elderly ward we found two purple folders used to identify patient preferences or requirements where the patient was suffering from dementia.
- Patients were referred to the SPCT via bleep, seen on the wards or via a paper form that was completed and forwarded on to the team.
- We did see instances of patients moved on to alternative wards with an available side room to enable relatives to stay with the patient. The relatives we spoke with were told that there were no camp beds available. They had to sleep on chairs within the side room with their relative. Podium 1 did have two camp beds available for relatives staying with patients on their ward.
- We observed a patient on a ward that was nil by mouth. They had been prescribed regular mouth care and 'taste for pleasure'. Even though the patient cannot eat or drink they could still experience the taste of food or drink in a safe manner.
- We found the viewing room within the emergency department very clinical but in need of redecoration. There were no seats for relatives to be able to sit with their loved ones. The lighting was very bright and this was not able to be dimmed.
- The mortuary and bereavement department was staffed between 8.30am and 4pm Monday to Friday. The public had access between 9.30am and 4pm. Outside of these hours, the duty porter had access. The hospital switchboard had contact details for the on-call mortuary service which was provided by mortuary staff. They were also able to offer advice and guidance outside of their normal working hours.
- The chaplaincy was able to provide psychological, spiritual and pastoral care for staff, patients, relatives and their friends. Christian, Jewish and Muslim faith leaders were readily available, however should another faith or religion be required, the chaplaincy team were able to source an appropriate person. Between March 2016 and August 2016 there were 128 referrals to the hospital chaplaincy team.
- A confidential befriending service was also available to patients via the chaplaincy.
- There was a chapel, multifaith room and a dedicated Muslim prayer room that was available for hospital users to access. Within the chapel, daily meditation was provided and a songs of praise event took place on a weekly basis. On Fridays a Muslim Imam attended the hospital to conduct prayers for those that wished to attend.
- Every week the chaplaincy held a songs of praise event in the chapel. They used a tape recorder to play the

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relevant music as there was no organ or piano available. The attendees sang along to the music. A further event conducted was 'And breathe...'. This was a relaxation idea to try to help reduce stress and anxiety for staff, patients and their relatives. The team had also recently decided to launch a study group. This consisted of a discussion around a religious text. There were texts from different denominations available. They had hoped to make this a regular occurrence for all who wished to attend.

- An Imam attended the hospital every Friday to conduct prayers for members of the muslim community. Staff, as well as patients were welcome to attend. When the Imam was away on a religious trip, he arranged cover for the hospital.
- The chaplains were involved with arranging funeral for premature babies every four to five weeks. The service was non-denominational and prayers for all religions were available via a printed sheet. The only concern was the iconography within the chapel where this service was held. This remained in place as the chaplain felt it was inappropriate for it to be removed temporarily for the service.
- Information leaflets were available within the mortuary to help relatives identify sources of help and next steps to take. The leaflets were only available in English which was unhelpful to the large multicultural community that used the hospital. Translators were available via The Big Word and there were two in-house translators based within the hospital.
- Leaflets were available throughout the hospital. The specific languages they were translated into were Greek, Polish and Turkish. This was to take into consideration the local population. We were told there were 152 languages spoken locally, therefore it would not be possible to provide leaflets in all languages.
- The bereavement officer was able to explain the processes they took a bereaved relative through after a patient has died. They explained how they could offer help and advice to the relatives. All valuables were retained by the ward and returned to the relatives there. The mortuary and bereavement officers did not have any dealings with this.
- Within the bereavement office, there were leaflets available for the relatives. All the leaflets were in English.

We were told the council will only accept requests and documentation in English, therefore they were not provided in any other language. Translators were available to the relatives, if required, via The Big Word.

- The bereavement officers were on hand to help relatives to obtain death certificates and help them understand processes after a patient's death. They were able to point them in the right direction to carry out any official registrations and paperwork, advise on funeral directors and any matters relating to deceased patients personal matters.
- The hospital provided a chapel and muslim prayer room. We were informed of a multi faith room for other denominations. The chapel had many icons and pictures that were in keeping with the Roman Catholic religion. There were also many crosses situated around the chapel. There were many cupboards and closets for robes and further icons as well as objects relating to the specific religion. There was a locked cupboard that contained very few religious books and only one or two scriptures for other religions. There was also a separate table at the back of the chapel to enable attendees to light candles if they had wished. There was a notice on the door that described the chapel as an 'inclusive Christian place of Worship' rather than a multi faith area.
- In an adjoining area based just outside the main building was a portacabin. This housed a multifaith area which included a muslim prayer room. The muslim prayer room contained many prayer books, a very small separate area for women and a male and female washing area. The washing area did not look clean or cared for. On the walls within the multifaith area, there were muslim scriptures. The second room within the multifaith area was inaccessible as the lock was broken. When we managed to gain access the room was very plain. It contained a few tables, chairs and no religious scripts, books or items at all. There were old half used bottles of water and a half eaten box of biscuits on the table. There were a few children's toys in the corner. The room was unclean and we were notified this was being used by the trust as a meeting room rather than a multifaith room. There was nothing in the room to depict it as anything other than a meeting room. There was also a sign on the door reminding the room users they were at risk of getting locked in due to the broken door. There were also cleaning trolleys blocking one of the entrances to the multifaith room and another stored in the corridor.

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- We spoke to the lead chaplain at length. The concern regarding the lack of multifaith scriptures and items was raised. This was something the chaplain said he would look into. There was no separate area for other denominations including Hindus, Sikhs or Jewish people.
- The chapel and multifaith rooms were kept locked outside of normal working hours, however access was possible via security. There was no access to religious books or scriptures; the very few available were locked away. The chaplain retained the keys for the cupboards at all times, there was no access outside of normal working hours.
- The time to obtain a chaplain or faith leader from an alternative faith was approximately one and a half to two hours. Every ward had a list of chaplains available and they were able to contact them directly if they felt this was required.

Access and flow

- The trust admitted patients from a number of boroughs for end of life and palliative care, however their main patient base was from Enfield, Haringey and Hertfordshire. Within the last six months, 60% of patients were from Enfield, 28% from Haringey and 9% were from Hertfordshire.
- There were no fast track admissions system for palliative or end of life care patients unless they were oncology patients. These patients had a passport giving them rapid access to the wards.
- Between March 2015 and April 2016 an average of 97.3% of patients were seen by the SPCT within 24 hours of referral.
- We observed a patient rapid discharge process. The nurse had to make multiple telephone calls to coordinate the process and obtain the relevant equipment. There were phone calls to the patients GP, the district nurse, hospice community team and a care providing agency. There was a multidisciplinary approach to this complex discharge; consultants from the hospital were also involved and helped to plan take home medications for the patient and to provide advice where needed. The patient appeared very distressed, however the nursing staff helped to reassure and calm them. Staff appeared unfamiliar with the rapid discharge process and needed guidance.
- The hospital conducted an audit of patients that died in their preferred location between September 2015 and August 2016. The trust found between 45% and 79% of patients were discharged before death, and between 21% and 55% of patients died in hospital. The trust had a problem with their recording system for statistics within this audit and believe 58% of patients were recorded as dying in their preferred place; however the SPCT explained getting a patient to their preferred place of death was not always possible due to matters outside of their control. They were able to provide an example of a case where a patient was ready to go home with their care plan in place, however the relatives felt unable to cope. The patient then remained in hospital to die.
- The trust performed better than the national average for patients concerns being listened to. The trust scored 89%. This was above the national average of 84%. However the trust performed significantly worse than the national average for the family's or next of kin's needs being listened to. The trust scored 16%, against the national average of 56%.
- The hospital were very proactive with rapid discharge for patients wishing to be cared for or to die in their preferred location. They had good links within the palliative care community to make this happen very quickly. They told us of a case where they had managed to get a patient discharged with a full care package within two hours.
- The speed at which the patient could be discharged to their preferred place of care or death was largely dependent on the local authority and the funding available. The trust were able to tell us about a patient they had managed to discharge from the hospital with a complete care package, including equipment, within two hours, although this was not a regular occurrence. The average discharge time was four hours. There were other incidences where this was not possible and the process could take up to two days.
- 12% of discharge waiting times were due to hospice and care homes. These can take longer to arrange due to availability of bed space.
- Advanced care planning was an issue for the team. They found this was not occurring early enough within the patients care plan. The SPCT found it was generally too late for this to occur as the patient was too unwell by the time they were referred to them. There were also some cultural and religious issues that made advanced care planning very difficult. Some cultures did not recognise this service and therefore limited plans could be made for the patient entering the last days and hours of life.

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Learning from complaints and concerns

- We found incidents were being logged on the trust's electronic reporting system, however there were recurrent themes of a lack of feedback for the reportee and the department.
- Complaints relating to end of life care had not been coded correctly, therefore the department were unaware of complaints that may have been relevant. They sought to address this issue by working with the complaints department, and providing them with a list of key words that may have trigger a relationship to end of life care. This was an ongoing process and the two departments were working closely to address the issues identified.
- During the inspection we found it hard to find learning that had taken place as a result of reported incidents. The incidents observed generally occurred a number of times and therefore it was clear the situation or incidents had not been addressed. We found this across departments, therefore feel this was a trust wide issue.
- The Patient Advice Liaison Service (PALS) was available Monday to Friday 9am until 5pm. They had an office based within the hospital building where patients and relatives could visit, if they had a concern or a complaint about the hospital or the treatment they received. They also provided a telephone number and an answerphone service for out of hours messages, as well as an email address for contacting the service. The service was run by two officers. They were involved with end of life patients via their relatives. There were times where relatives felt they would have like better access to the patient, especially within cultures that have very large or extended family. PALS were able to assist and facilitate solutions to issues that arose, and reduce frustrations for the relatives and friends. The team were also available to help the family make arrangements on or after death of their relative. Both members of the team were trained counsellors.

Are end of life care services well-led?

Requires improvement



We rated leadership as requires improvement because:

- There was no clear EoLC strategy. The hospital were aware of improvements they needed to make, however they did not have a clear action plan to achieve this.
- The last inspection of the trust in 2014 highlighted the lack of a non-executive director (NED) with responsibility for end of life care. Staff we spoke with including senior staff were not aware of a NED with EoLC responsibility. The trust informed us after we brought this issue to their attention that one of the boards NEDs had been given the EoLC responsibility in June 2016.
- The trust had failed to collect data and audit outcomes of bereaved relatives experiences. They had a bereavement survey written and ready to send out to relatives over a year ago, however this had not been utilised.
- The trust had only recorded one EoLC concern on their risk register. This was a concern as it had not been updated to reflect new risks or updates to the existing risks.

However:

- The SPCT had made good progress with integrating within the hospital team to make themselves more accessible and to add value to the medical teams throughout the trust.
- There was a good relationship between the SPCT and the critical care unit (CCU). A member of CCU had spent a week with the SPCT to train and take back learning to their department to share knowledge and experiences with their department.
- The consultants and CNS's worked well together and showed good communication. The consultants and nursing staff reported to the DoN and medical director. There was a vacancy for a lead cancer nurse within the SPCT and also a vacancy for a lead palliative CNS at the time of our inspection.
- The trust has increased spending on EoLC by 43% over the last two financial years.

Vision and strategy for this service

- The reporting structure within the SPCT was divided into nursing and consultant roles. The nursing structure consisted of three CNSs who reported to the acting nurse consultant team leader. The team leader would have reported to the lead cancer nurse, however this

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position was vacant at the time of the inspection. The lead cancer nurse would then have reported to the deputy director of nursing (DDN) who was also the chair of the EoLC steering group.

- There were three part time consultants that made up 1 WTE post. The lead consultant spent the most time within the department. The consultants reported to the consultant oncologist who was the lead for oncology and palliative care. The consultant reported to the clinical director who was also the chair of the Haringey community palliative care services operational board who reported directly to the medical director and the DoN.
- There was no clear strategy for end of life care within the trust. This topic was discussed at the August 2016 End of Life Care Steering Group and a draft strategy was requested to be prepared in time for the next meeting.
- The overall vision for the SPCT was to provide a full seven day service and the trust was aware of the additional resources required to achieve this. However financial performance of the Trust has necessitated a graduated and we saw evidence funding for the SPCT had increased by 43% in the last two years.
- The SPCT were very proactive in trying to arrange training for the rest of the hospital staff although they were constantly having to push for acceptance and for staff to be released from their duties to undertake the training.

Governance, risk management and quality measurement

- The trust had only recorded one concern on their risk register. They stated they only provided a palliative care service Monday to Friday 9am until 5pm, however there was no service provided during evenings and weekends. The hospital placed this risk on their register as they were aware the trust was not compliant with national recommendations. The trust failed to place staffing concerns and inconsistent and failing audit results on their risk register amongst other concerns we found during our inspection.
- The trust had identified other areas that required improvement, however they had not place these on the risk register.
- The EoLC Operational Policy was updated and reviewed on a yearly basis by the lead palliative care consultant.
- The end of life steering group met quarterly to discuss policy, improvements and changes required within the

service. The minutes from previous meetings were not always reviewed or actioned. Some action points were on going and were brought forwards to the next meeting. Some of the issues identified by the steering group were the lack of seven day services for EoLC, The need to appoint an non-executive director for EoLC services and the business case put forwards by the SPCT for a fifth CNS to join the SPCT, as well as the lack of strategy for EoLC.

- Every month the SPCT had a meeting to discuss policies and any changes that may need to have been made. The chaplain attended this meeting to give input and offer advice.
- The therapies team felt they were under pressure due to lack of staff. They said that they didn't feel discharges were always safe due to the lack of time they were able to spend with the patient. They found there was difficulties retaining staff within the department due to the pressures placed upon the team.

Leadership of service

- Leadership of EoLC was managed by the palliative care lead consultant. They were very clear as to the limitations of the service and what needed to be achieved.
- The SPCT had an acting lead nurse, however there was no lead cancer nurse. This position was vacant, however the trust had placed an advert to fill the role.
- The last inspection of the trust in 2014 highlighted the lack of a non-executive director with responsibility for end of life care. However, this role was only added to the existing responsibilities of a non-executive director on June 2016. At the time of our inspection, it was unclear how this new post had influenced the vision and future strategy of the SPCT.
- The lead consultant had established the number of CNSs required to run a full seven day service as per NICE (National Institute for Health and Care Excellence) guidelines for staffing.
- Once extra staffing for the SPCT could be agreed, the PallE8 strategy also needed funding. It was believed once the funding for these two elements could be secured, the trust would then be in a better position to be able to meet their targets and priorities. Until such a time as this funding could be sourced, advancement was not seen as a viable option.
- Although we found there had been some positive changes since the last inspection, we also found that

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there had been no action taken on some issues we identified during in 2014. Positive changes included an increase in staffing levels, an EoLC training programme, a rapid discharge pathway and end of life champions had been placed on wards. We found that EoLC information notice boards had been placed on each ward and two EoLC rooms had been created on Podium 1. Despite the changes that had been implemented, areas for improvement identified from the last inspection had not all taken place, which was a cause for concern. At the time of the inspection, the trust had still not appointed a non executive director (NED) with responsibility for EoLC. The trust had only managed to meet two out of the 10 KPIs for the NCD audit. One of the KPIs the trust had not met showed that there was no NED for EoLC. We acknowledge that shortly after our inspection, the trust provided evidence to show that a NED was now in place, however it was over two years since the trust had initially been notified of this. We were also informed by mortuary staff that the trust still had issues with the capacity of the mortuary at times; temporary fridges were still used to fill this requirement despite outcomes from the previous report. During the last inspection, we identified a lack of guidance for staff around the referral of patients to the SPCT. During our inspection, some staff were aware of an out of hours pocket guide produced by the SPCT, which aimed to give some guidance to staff; however the majority of staff that we spoke with had either never seen this pocket guide, didn't know where to find it or did not know that it existed.

- The staff within the SPCT worked well together and the consultants and CNSs had great respect for each other. There was a sense of a combined and committed team working with the resources they had available, however they were very stretched and tired. It was clear they were in need of extra staff to cover their workload. The SPCT felt having staffing and funding would help them to progress to meet the targets within the NCD audit, and the 5 priorities of care of the dying.
- There was a large consultant presence on a Wednesday morning. We asked if this could be utilised in any other way. The lead consultant was very clear that it was not possible to have weekend or out of hours cover as the consultants would not work without a palliative care CNS being available. At the time of our inspection, there was no CNS cover outside of working hours.

Culture within the service

- During our inspection, we found a very positive attitude towards the SPCT from the wards and medical staff, however the SPCT said they felt they were struggling to be accepted by some of the consultants and departments.
- All of the wards that we visited stated they called the SPCT if they had any patients classed as end of life or required palliative care. The ward staff we spoke with were happy with the process they followed to obtain assistance from the SPCT and were very pleased with the rapid and professional service they delivered.
 - All ward staff that we spoke with were aware of the iPELC document and had received training on how to complete this.
- The SPCT felt they were understaffed for the level of service they needed to provide. They felt it had taken a large amount of time and effort for other departments within the hospital to recognise the expertise and assistance they had brought to palliative and end of life care patients; however they felt they had made good progress with other professional colleagues and their relationships were continuing to grow.
- There was a confusion between hospital staff as to the definition of end of life care. NICE guidance defines end of life patients as being within the last 12 months of their life. Hospital staff gave us varying answers as to what constitutes end of life. Some staff felt this was as per the definition, whereas other staff said this was last days or hours of life.
- We discussed the term 'end of life' with the lead consultant and she was not surprised with the was difference of opinion. She said if you were to be in a room full of end of life care consultants, the view on this definition would have been completely varied.

Public engagement

- At the time of the inspection, the trust did not carry out a bereavement survey, therefore they could not benchmark against another trust. We were assured by the lead consultant the survey was completed and ready to send out with immediate effect.
- We asked the trust how they were assuring themselves that the care they were providing was to a good standard, if they were not able to measure themselves against other trusts. We were told patients and their relatives were asked for their feedback.

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- A scheme was developed by the SPCT offering to send a member of the SPCT to the patients house to discuss their experiences. Seven patients were asked to allow a visit however no patients accepted the offer.
- There was an end of life steering group used for their comments, opinions and to help create policies.

Staff engagement

- The SPCT was a small very busy team. There were four nurses and two palliative care consultants that were based within the hospital. They felt their role was more advisory and training than to see all the palliative and end of life care patients. The SPCT felt that end of life care was everyone's business. Rather than having to see every patient, the team trained some members of ward staff and other clinicians to be able to deal with end of life patients. They saw this as a positive move forward through advice and education.
- The portering staff attended Schwartz rounds conducted by the trust. They also had access to counselling if this was required.
- Every ward had a palliative/end of life care notice board. This was kept up to date by the SPCT.
- There was a good relationship between the critical care unit (CCU) and the SPCT. A CCU consultant spent a week with the SPCT on a placement and completed the full training day for end of life care patients. They built a good working relationship between the two departments. CCU actively referred patients to the SPCT.
- A patient safety group led by CCU nurses was used to help reduce the number of futile DNACPRs being issued. Training occurred, and as a result the number of futile DNACPRs reduced.
- The chaplains attended the patient experience group and patient information group to listen to their feedback and offer advice.
- Mortuary staff were not offered any form of clinical supervision; if they felt they required counselling, they had to approach occupational health for referral. The team did not sit on the end of life steering group, however the bereavement officers did have an input

into the iPELC document for care after death. If there was an opportunity, the bereavement officers would attend the end of life care meetings, however this was a very rare occurrence.

Innovation, improvement and sustainability

- The trust stated they had seen an increase in non-malignant referrals to the SPCT since 2014. This was a positive outcome as it showed end of life care was identified as a possible need within other departments and services throughout the trust realised patients died from causes other than cancer related conditions. To identify an end of life care patient early enough allowed for advanced care planning and the patient to have a greater choice over their preferred care and treatment.
- MacMillan had a scheme to fund a CNS for three years, if the hospital made a commitment to secure the post long term after the funding has finished. To date, the hospital had been unable to make that commitment, however the SPCT had put a business case forwards for consideration. The case was discussed at the management meeting, however it was not approved. The case will be reviewed in the future. There was no date provided for this review.
- The SPCT felt they had made good progress with integrating with teams throughout the hospital, however they recognise that there is still some way to go.
- The trust were looking into employing a dedicated person from the SPCT trained to attend care homes assist the patient, the relatives and the care home with creating advanced care plans for the patient. This role would be funded by the Clinical Commissioning Group (CCG). It was thought the scheme would start with two nursing homes in the local area and expand into the local area.
- The chaplains were working with the clinical psychology department to try to set up a formal debriefing and psychological service for staff, following a traumatic incident. This discussion was on going at the time of our inspection.

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

Information about the service

North Middlesex University NHS Trust provided an outpatient service of 317,589 appointments from March 2015 to February 2016. A further 149,283 appointments were provided in additional clinic times to reduce waiting times and significantly increase the number of overall appointments.

Outpatient clinics at North Middlesex hospital were across a wide range of specialisms, including ophthalmology, dermatology, cardiology, respiratory, diabetes, breast and gastroenterology.

Diagnostic Imaging services included plain film X-ray, ultrasound, interventional, mammography, CT and MRI.

Over the inspection days we spoke with 23 patients across the services. We also spoke to a wide range of staff at all levels including nurses, managers, administrative staff, radiographers, occupational therapists, physiotherapists and other allied health professionals who make up the vital members of healthcare teams.

We received feedback from our listening event and staff focus groups.

We also reviewed trust policies and procedures and performance data.

Summary of findings

We rated this service as requires improvement because:

- Staff reported patient safety incidents and there was some evidence of learning from incidents and patient complaints. However, feedback from staff did not demonstrate consistency in all areas. There was a process in place to report ionising radiation medical exposure (IR(ME)R) incidents and the correct procedures were followed. However, the governance and monitoring arrangements need to be strengthened as these had been lacking in past months.
- Overall, patients were treated with dignity, respect and care by staff. Although, some patients told us staff were rude and uncaring. Most patients spoke positively about staff but did not always feel well informed about their care and the procedures being undertaken.
- The services we inspected were generally clean but there were some areas that needed further attention.
- There was a shortage of key staff, in particular band 5 and 6 radiographers, ultrasonographers, histopathologist and outpatient nurses. Staff morale was mixed but we observed a good team spirit and optimism for the future.
- There were policies and procedures in place in relation to consent and the Deprivation of Liberty Safeguards. However, the staff we spoke with had very limited understanding of these issues.

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- Records were not always available for clinics although improvements had been made in recent months.
- There was limited support for patients with a learning disability or living with dementia.
- The diagnostic imaging department had produced a local workforce plan so that projected capacity would meet demand from 2015-2020. However, there was no capital improvement plan for ageing equipment.
- The proportion of people waiting less than 62 days from urgent GP referral to first definitive treatment was below the national average and had deteriorated in the first quarter of 2016/17.

However:

- The percentage of patients seen within two weeks for all cancers was higher than the national average. Also, the cancer waiting times for people waiting less than 31 days from diagnosis to first definitive treatment were higher than the national average and above the standard target of 96%.
- Nursing staff vacancy levels were low. A few vacancies were currently being recruited to. The diagnostic imaging vacancies were higher, particularly ultrasonographers. However, there was an ongoing recruitment and retention plan in place.
- There was evidence of service planning to meet patient need such as the emergency eye service offered Monday to Friday 8.30am to 4pm for patients with sight threatening eye conditions, requiring urgent specialist ophthalmic treatment. There were extended days for diagnostic imaging appointments. National waiting times were met for outpatient appointments and access to diagnostic imaging.
- Staff had good access to evidence based protocols and pathways. There was limited audit of patient waiting times for clinics but patients received good communication and support during their time in the outpatients and diagnostics departments.
- All staff we spoke with understood how to obtain informed consent. Safety measures were in place for consenting to diagnostic imaging procedures.
- Staff were aware of the complaints policy and told us how most complaints and concerns were resolved locally.

- Governance processes were in a process of change across outpatients and diagnostics and the new structure was not yet embedded. Clinical governance knowledge was limited within certain divisions of outpatients. However, good progress was evident for improving services for patients.
- We found evidence of strong local leadership and a positive culture of support, teamwork and focus on patient care.
- Staff were aware of their responsibilities within adult and children safeguarding practices and good support was available within the hospital.

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Are outpatient and diagnostic imaging services safe?

Requires improvement



We rated safe as requires improvement because:

- Some incidents were reported and investigated appropriately and learning were shared. However, staff told us they did not report many incidents due to limited time or deciding a particular issue. For example missing notes were not always seen or reported as an incident. Staff in the outpatients departments were aware of the incident reporting procedures but were less aware of feedback mechanisms.
- Staff in diagnostic imaging were all aware of the incident reporting procedures. However, staff told us there was limited or no feedback of lessons learnt from these incidents reported.
- The environment was not always clean in the areas we visited. Staff told us about the many issues they had with the contracted cleaning and portering service. We saw staff adhering to infection control procedures. Cleaning schedules had not been completed by staff in outpatients for several months.
- The diagnostic imaging department had policies and procedures in place based on the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and Ionising Radiation Regulations 1999 (IRR99). These regulations are to protect patients, staff and the public. Some of these policies and procedures were past their review date but were in the process of being updated. The department had good support networks in place for expert advice and had recently implemented regular departmental radiation governance meetings. These had not been in place previously.
- There were not always sufficient staff in outpatients to manage the service particularly due to extra clinic sessions. Vacancies in diagnostic imaging meant the ultrasound service in particular was under strain to manage the workload. Staff were well supported for training and mandatory training levels were meeting trust compliance levels overall. Staff had a good understanding of safeguarding procedures.
- In the imaging department we observed the World Health Organisation (WHO) checklist for interventions was completed. We looked at the data from the June

2016 and saw the checklist was completed in only 56% of cases and written consent confirmed in 87% of cases. We saw a documented action plan to increase the use of the checklist.

However:

- The majority of records were available for outpatient appointments but a recent audit demonstrated that 14% were still missing. However, improvements had recently been made so that more notes were tracked and pulled ready for clinics.
- Patient protocols were in place in radiology and revised as required.

Incidents

- Incidents were reported and managed appropriately but any action and learning was not always shared with staff. Staff showed a good understanding of the incident management process which was accessed via the hospital intranet. Staff felt this process had improved recently. Staff in some areas stated that feedback did not occur or was unlikely. Staff in pathology held a weekly meeting to review incidents and look at trends. The incident report covering outpatient services reported a total of 91 patient safety incidents between June 2015 and June 2016. The majority of incidents reported were of low or no harm.
- There were three serious incidents recorded from August 2015 to July 2016 relating to a diagnostic delay. We saw these had been reported appropriately and notified to external regulatory bodies where necessary. Staff showed us the detailed reports outlining the incidents and the associated action plans. There were two radiation incidents that had been reported to the Care Quality Commission following correct procedures. The policy was in the process of being updated.
- We reviewed the action plan following an incident reported in March 2016. Learning was to be shared to all radiology staff about the trust naso-gastric tube policy. We spoke with staff who were not aware of this training.
- Senior managers told us they encouraged a culture of open incident reporting and staff confirmed this. However, staff told us they could not always find the time to report an incidence. Some staff said they felt blamed for raising concerns and were afraid to do so.
- We looked at the minutes for the Clinical Business Unit Patient and Safety Quality meeting held in July 2016. Incidents were broken down by level of severity and

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trends were discussed. Diagnostic imaging staff gave an example of how practice was to be changed in the process for flagging unexpected results following a trend in incident reporting.

- There were no 'never events' reported between August 2015 and July 2016. (never events are serious, largely preventable patient safety incidents, which should not occur if the available preventable measures have been implemented).
- We saw the hospital Duty of Candour policy and templates for duty of candour letters. Staff we spoke to were not sure of the duty of candour policy and their obligations.
- A detailed review of imaging reporting backlog resulted in two patients being informed of clinical harm potentially caused by the delay. The correct duty of candour process was followed.

Cleanliness, infection control and hygiene

- During inspection, we found out that not all areas in outpatients and diagnostics appeared clean and tidy. This was particularly noticeable in the respiratory and physiology clinic area as the floors and sinks were not clean. Staff told us they had been waiting three days for the delivery of hand towels.
- We noted that records of daily cleaning were visible and complete in all the diagnostic imaging rooms.
- We observed staff using infection control practices. Posters prompting hand hygiene were clearly displayed.
- The outpatient and diagnostic imaging departments had achieved 100% on their hand hygiene audits from April to August 2016. Hand sanitiser gel was available at numerous points across the departments although some were found to be empty.
- We noted that all staff were 'bare below the elbows' in clinical areas. This reduced the risk of infections to staff and patients and was in line with good practice.
- All sinks were hand wash stations and fully compliant with HBN 0009 Infection Control in the Built Environment (March 2013), which is the department of health best practice guidance.
- All soft furnishings were wipeable and in good condition.
- The vinyl floor in the outpatients departments was in poor condition in some areas and not adequately cleaned.

- There were adequate supplies of personal protective equipment (PPE) including glove and apron dispensers throughout the outpatient areas and lead protection in diagnostic imaging.
- The outpatient department was given prior notice of infectious patients by the infection control team. There was not a dedicated room but once the clinic room had been used, the rapid response cleaning team would be contacted and the room will be deep cleaned before making it available for further use.
- The hospital reported that 100% of outpatient nursing staff had attended infection prevention and control training against a target of 95% in the year to date.
- Infection control policies were available on the intranet and staff were able to show them to us easily.
- The outpatients department had infection prevention and control link nurses in place that attended infection control meetings and then reported back to the rest of the team.
- Radioactive spillage kits were available in nuclear medicine and staff knew how to use them. All radiation waste within nuclear medicine was disposed of appropriately and the process fully documented. Reports were sent weekly to the Radiation Protection Advisor and monthly to the Environment Agency.
- We noted good waste streaming with the use of hazardous waste bins and recycling bins.
- There were clear notices around the hospital detailing hand hygiene and infection control measures for patients and visitors.

Environment and equipment

- The diagnostic imaging department had a local risk register in place. This included risk to in-patients being left unattended in the waiting area. An action had been agreed to recruit a healthcare assistant to work specifically in that area although this role had not yet started.
- Resuscitation equipment was available across outpatients and diagnostics and checked daily. New checks had been put in place to ensure the resuscitation trolley was checked in diagnostic imaging at the weekends.
- The bariatric equipment was not available in outpatients. The staff we spoke to did not feel it was necessary to provide this equipment.

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- The laser equipment in outpatients was checked appropriately. There was a Laser Protection Advisor (LPA) in place to give advice and support.
- The hospital medical physics department check all outpatient equipment on an annual basis. A decision is made as to whether the equipment will be serviced in-house or outsourced to a private company.
- All portable appliance testing (PAT) testing of outpatient equipment was in date.
- We observed radiology staff wearing specialised personal protective aprons. These were available for use within all radiation areas and on mobile equipment. Staff were also seen wearing personal radiation dose monitors which were monitored in accordance with the relevant legislation.
- The patient waiting areas were free from any hazards and overall, the areas were well decorated.
- All radiation areas had secure access. In MRI there were safety notices on the doors into the suite which stipulated safety measures such as restrictions with regards to loose metal.
- Environment issues were on the risk register for the medical records library. Staff told us there were repeated incidents of sewerage leakage from the plumbing system.

Medicines

- The medicines cupboards we inspected were locked and secure, all stock was within expiry date and there was evidence of stock rotation. We saw the use of 'short date' labels to make staff aware of expiring medicines.
- We did not observe any medications left out in unsecured areas although the key was not stored in a secure place and could have been accessed by another member of staff or the public.
- The majority of outpatient clinics we visited did not store medicines. Where medicines were kept in a clinic, they were stored securely. We noted the temperature of one clinic fridge was monitored on a daily basis. There were no temperature recordings of any concern.
- Prescription pads were collected from the hospital pharmacy for use in outpatients. There was no tracking system in place and therefore the process could not assure that all prescription pads were accounted for at the end of each clinic.
- A nurse-led anticoagulant clinic ran daily with consultant and pharmacist support. Protocols were in

place to allow the management of the anticoagulant according to the blood test results. Patients and their GPs were informed of dose changes and concerns promptly.

Records

- We observed that staff in the outpatient department often left the medical records in use unattended.
- We spoke to a receptionist who told us that medical records were collected from the medical records department and made ready for the clinic. Staff told us that missing records were improving but when this happened there was a system in place to set up a temporary record using the electronic patient information. The temporary files were clearly marked so that they could be reconciled with the permanent record when located.
- All the notes were available for the clinics we inspected.
- We looked at the audit of records pulled for appointments. We found an improvement from 49% in March 2016 to 80.9% in September 2016. Some staff expressed concern that some of the patient notes were incomplete. Staff in the records department told us they were now too busy to look through notes for completeness.
- We were told notes were not always logged for tracking by other departments across the hospital. This meant they are not always easily located and important clinical information might not always be available for patient consultations.
- The staff we spoke to in diagnostic imaging had a good understanding of patient confidentiality and data protection and had attended information governance training. We saw the receptionist demonstrate this by double checking patients details when they attended.
- The diagnostic imaging department had a central electronic patient records system to record comprehensive details of each patient's imaging history. Any paper records such as MRI safety checklists were scanned into the system. We looked at the MRI paper records and saw they were checked and signed by the radiographer.
- Staff in the diagnostic imaging department were able to show us how the radiation doses were recorded on the system for each procedure.
- All in-patient and accident and emergency referrals for diagnostic imaging were now sent electronically.

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Safeguarding

- The outpatients nursing staff reported a compliance level of only 25% for adult safeguarding level 2 training against a target of 95%. Compliance for children's level 2 was 100% against the trust target of 95%.
- The hospital had policies for safeguarding children and vulnerable adults.
- The staff we spoke with did not always demonstrate they understood safeguarding processes and how to raise an alert. They could, however, access support from senior staff if needed.
- We observed an incident within outpatients regarding a patient with special needs. The patient was in a lot of distress and it took some time to address this and move the patient to a quiet area. The patient was known to the clinic and no prior support or arrangements had been made to support the patient more appropriately. A potential safeguarding alert needed to be raised and we were not assured that staff would have known what to do in the absence of senior staff being available. We spoke with some of the nurses involved and they were not aware of the learning disabilities passport which is in use across the trust. This passport was designed to give hospital staff helpful information to make patients feel more comfortable about the hospital visit.

Mandatory training

- Mandatory training included infection control, health and safety, fire safety, conflict resolution and safeguarding.
- Staff told us they were achieving mandatory training targets although reported figures were variable. There was a shortage of staff in the respiratory clinic on the day of the inspection as most staff were attending fire training.
- Mandatory training included e-learning and face to face meetings. Staff told us the quality of the training was good.
- The trust target for all mandatory training was 95%. Targets were not being met in outpatients and diagnostic imaging for some of the subjects particularly moving and handling, basic life support and adult safeguarding.

Assessing and responding to patient risk

- The hospital had a medical physics expert commissioned from a neighbouring hospital, available

and contactable for consultation to give advice on radiation protection for medical exposures in radiological procedures. This was in line with IR(ME)R guidance.

- The diagnostic imaging department had named Radiation Protection Supervisors (RPS) to give advice when needed to ensure patient safety and minimise radiation risk. They were adequately trained and had all attended training.
- Quality assurance tests on the x-ray equipment were done daily prior to the service starting. Any trends or increases in exposure were reported to the RPS and investigated immediately.
- The RPSs attended the radiation protection governance meeting.
- Dose reference levels were displayed in all X-ray rooms.
- An adapted version of the world health organisation (WHO) checklist was used for some interventional procedures.
- The Ionising Radiation Medical Exposure Regulations (IRMER) employer's procedures had been revised but needed to be organised into a comprehensive document.
- We saw local rules were in place and available for all staff to follow in the imaging areas we visited. There were also clearly visible on the mobile imaging equipment. Staff were aware of the local rules and how to use them in their practice.
- Radiation risk assessments were done when new equipment was installed. Senior staff told us they had not undertaken any recent risk assessments and more work was needed to fully meet the Ionising Radiation Regulations 1999 (IRR'99). We spoke with staff in the CT department who told us about the full range of quality assurance tests they carried out to ensure the equipment complied with required safety parameters.
- Systems were in place to contact an emergency response team if required in outpatient and diagnostic imaging areas.
- Resuscitation trolleys were available across the outpatient and diagnostic imaging areas.
- A falls box was available for staff to use in diagnostic imaging.

Nursing/ radiology and pathology staffing

- There were dedicated nursing and health care assistant staff across the outpatients department.

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- Staff told us the staffing levels were not adequate to meet demand and a business case had been agreed to recruit more healthcare support workers. Clinics were open from Monday to Friday with extra clinics scheduled in the evening and at the weekends. More reception staff were required to support the extra clinics and three additional apprentices had been agreed. These staff were due to start as soon as possible.
- We saw evidence of planned staff for clinics to meet consultant and patient need.
- Bank and agency staff were used in the diagnostic imaging department but most of these staff had a long term relationship with the hospital.
- There was a shortage of sonographers across the ultrasound service.
- Diagnostic imaging services offered student radiographer placements. We spoke with two staff members who had previously been students at the hospital. They felt the department offered them good support and a varied career pathway.
- Healthcare scientists were not employed directly by the trust and were contracted with an external provider of pathology services.

Medical staffing

- Across the outpatient service medical staffing was adequate. There were enough consultants to see the booked patients although the longest waits were in dermatology.
- Consultant appointment times were aligned to clinic times.
- One new breast consultant posts had been recruited for radiology services and started in June 2016.
- There was a long term vacant histopathologist post in the pathology department. The staffing levels for microbiology were in breach of the NICE guidance for Antibiotic Stewardship and a further post had been agreed.
- A new business case was in progress to recruit a Clinical Infectious Diseases doctor on 0.5WTE.

Major incident awareness and training

- The trust had a major incident plan in place and there was evidence of business continuity plans for both outpatients and diagnostic imaging.
- OPD was designated as an ambulatory care decant area for the emergency department during a major external or internal incident. We saw this in action on the day of

the inspection. However, many of the outpatient staff we spoke to felt there had been little communication about the changes and it had created a 'knock-on' effect in terms of access and waiting times to the outpatient clinics.

- Staff understood what actions to take in response to a major incident and in particular for a fire.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We did not have sufficient evidence to rate effectiveness of the outpatients and diagnostic imaging services.

- There was little evidence of clinical audit in the OPD (either medical or nursing led).
- Appraisal rates were below the trust target for diagnostic imaging staff and phlebotomy staff.

We also noted that:

- Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice.
- Staff obtained written and verbal consent to care and treatment which was in line with legislation and guidance.
- Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice. Staff felt supported to deliver care and treatment to an appropriate standard, including having relevant training.

Evidence-based care and treatment

- Staff had access to evidence based protocols and pathways based on NICE and Royal College guidelines.
- Relevant clinical guidelines and standard operating procedures were available for all imaging tests and staff were able to show these to us during the inspection.
- NICE guidelines and minimum standards from the British Association of Dermatologists were followed for phototherapy services.
- National Royal College of Nursing guidelines were used regarding the self-administration of anti-rheumatic drugs.

Outpatients and diagnostic imaging

- We talked with staff in the diabetes department and saw they followed the NICE guidelines for the management of type 2 diabetes in adults.
- The 2014 annual RPA's report showed a list of compliance actions to be taken. We were not provided with an updated action plan to confirm all necessary steps had been out in place.
- We saw a written update from the RPA on the proposals for the new radiation safety legislation in 2018 giving advice and guidance as to the next steps required.
- An audit of lead protection equipment had been completed in February 2016 and actions completed. An audit of forms completed by people holding patients during x-ray examinations had been completed and re-audited. This showed an increase in forms being completed from 6% to 50% in September 2016.
- We looked at the diagnostic imaging local audit plan and noted that a monthly audit afternoon was to be re-instated in October 2016.
- We spoke with staff in the ultrasound department. They told us they were part of a research programme looking at pre-eclampsia in early pregnancy. They looked at their protocols as required during multi-disciplinary academic meetings. They had recently updated their protocol to meet the NICE guidelines for renal failure.
- A urology clinical nurse specialist and a diabetic clinical nurse specialist were able to demonstrate how the specialist clinics followed NICE guidelines in improving outcomes in urological cancers and managing type 1 and type 2 diabetes.

Pain relief

- We observed that prescription pads were available in clinics and we saw that prescriptions for pain relief were recorded in patients' notes.
- Pain relief (analgesia) and local anaesthetics were available for patients who needed this during procedures.
- A pain score was completed in interventional radiology in order to monitor a patient's requirements for pain relief.

Patient outcomes

- The follow up to new outpatient rate was slightly below the England average from July 2015 to February 2016.
- The hospital had started collecting data to show the percentage of patients waiting over 30 minutes to see a

clinician. In diagnostic imaging, the results from a recent audit showed that 30% of patients waited over thirty minutes from the time of their appointments. 22.5% of these patients waited over two hours.

- The DNA rate was consistently higher than the national average from March 2015 to February 2016 in outpatients. The year to date DNA rate was 14.2% against an internal target of 9.6%. A new text message service was being trialled to see if this would address the high DNA rate. Staff in the bookings office told us they thought this was making a difference.
- We spoke with the reception staff as to how they managed long waits. They told us they updated the white boards but we did not see this in practice and many of the times were incorrect.
- All patient outcome forms from outpatient clinics were updated electronically and monitored on a daily basis. There was a significant backlog of patients who were not able to be booked a follow up appointment due to lack of capacity in the clinics.
- There were no audits of patient outcomes for outpatient care and treatment.

Competent staff

- An induction plan was in place for all new staff to gain competencies for their job role in diagnostic imaging. Continual professional development was promoted in the department. Some staff in outpatients told us they had only recently had an appraisal which was the first one for several years. The overall appraisal rate for the directorate was 74.5% in May 2016 against a trust target of 80%. We noted staff in the health records department had achieved 100% compliance for their appraisals.
- There was little evidence of professional development within the outpatient department. Many of the outpatient administration and clerical staff told us it was often too busy to attend mandatory training.
- Completion of mandatory training levels was good across most areas of outpatients and diagnostic imaging.
- On starting work at the trust, staff attended a corporate induction. Some administration staff told us they did not feel supported when starting their roles as there was no local induction to their specific area.
- Specialist nurses worked within the outpatients department providing nurse-led clinics alongside medical colleagues.

Outpatients and diagnostic imaging

- The imaging department were seen to have effective clinical supervision and mentoring systems in place for radiology reporting staff. There were good examples of advanced practice for radiographers.
- A Service Level Agreement (SLA) was in place to support the trust with access to a Radiation Protection Advisor (RPA) AS REQUIRED BY IRR'99 and a Medical Physics Expert (MPE) as required under IRMER. The duties required of these roles were satisfactorily carried out by a registered physicist.
- We spoke with one Radiation Protection Supervisor (RPS) within the diagnostic imaging department. They had received update training and were supported by the trust to attend the three day course.
- There were examples of apprentices being used effectively in roles across outpatient and diagnostic services.
- The radiography department services were available seven days a week. The MRI and CT service were open extended hours from Monday to Friday with weekend sessions available Saturday and Sunday.
- GP referrals were offered an open access clinic service 8am-7pm, seven days a week.
- Radiologists were on site until 11pm each weekday evening with the on-call provided by an external provider. There was a weekend on-call rota with the outsourced company again used from 11pm.
- Pathology laboratory was available out of hours on an on call basis. Blood sciences were available 7 days, 24 hours a day. Microbiology service was available Monday to Friday 9.00am to 17.00pm and out of hours had an on call service.

Multidisciplinary working

- At the time of the inspection the outpatient department did not hold pre clinic briefings.
- Consultant radiologists were core members at the cancer MDT meetings.
- Joint working between interventional radiology and cardiology had been problematic. The issues had been escalated and a local agreement reached but some senior staff felt the solutions were unsustainable.
- Pathology staff attended MDT meetings to ensure the correct tests were done in a timely manner.
- Staff were able to access pharmacy support in clinics if needed.
- A nurse-led anticoagulant clinic ran daily with consultant and pharmacist support. Protocols were in place to allow the management of the anticoagulant according to the blood test results. Patients and their GPs were informed of dose changes and concerns promptly.
- We spoke with staff in the breast clinic. They offered one stop clinics Monday-Thursday each week. They held an MDT meeting weekly attended by various members of the wider healthcare team. Diagnostic imaging staff who attended this meeting felt it was invaluable for their work.

Seven-day services

- The outpatients department was open Monday to Friday 8am to 5.30pm, with frequent 'waiting list reduction' clinics being held at the weekends.

Access to information

- Staff told us and we saw that they had access to trust policies and procedures on the intranet.
- Patient notes required for weekend clinics were pulled in advance and ready to collect on Fridays.
- The paediatric patient notes were being transferred onto the electronic system. This category of notes was the pilot stage before the full roll out of the project. Staff told us there were delays in this project. We observed both paper notes and electronic notes in use in the outpatient clinics.
- There was no electronic tagging of patient notes within the hospital. Staff told us notes were often hard to locate as staff did not correctly follow the logging system to ensure notes could be found.
- X ray and diagnostic imaging results were available electronically which made them promptly and readily accessible to staff.
- Electronic access to pathology, microbiology and radiology results were available.
- The diagnostic imaging department supported the Image Exchange Portal (IEP) where images could be sent to other hospitals. The system had the capability to also attach the imaging report.
- Explanatory leaflets were available to assist staff to explain procedures and investigations to patients.
- Pre-operatively patients had discussions with the nursing staff to ensure they understood the procedure.
- Information boards were displayed around the department to give specific information to patients and staff such as patient experience feedback.

Outpatients and diagnostic imaging

- An explanation of ionising radiation and its effects was displayed on the reception desk of ground floor x-ray.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The staff demonstrated competence in seeking verbal and written consent from patients. Verbal consent was observed in the X-ray room and the gynaecology outpatient clinic.
- Staff were not clear of their duties and responsibilities in relation to patients who lacked mental capacity. They demonstrated limited knowledge and understanding of Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS).
- Staff encouraged carers to escort their relative to appointments in order to offer support.
- We saw examples of accurately completed consent forms.

Are outpatient and diagnostic imaging services caring?

Requires improvement 

We rated caring as requires improvement because:

- Some patients gave examples of good care but several said care was lacking. We were given some negative feedback from patients and staff about how care was given.
- The Friends and Family feedback survey showed only 78% of patients would recommend the service received in outpatients.
- Patients' privacy and dignity was not always maintained within the diagnostic imaging department.

However:

- Throughout the inspection, we witnessed good care being given. Patients were given emotional support when required.
- There was a strong individual response from staff we spoke with about wanting to make things right for the patient. There was a sense that this had not always been the focus of the trust and things needed to change.

- We observed the staff supporting patients that required any assistance. There were quiet rooms available for any patients who were to be given bad news and a cancer information centre located at the hospital.
- Staff demonstrated a good understanding of the privacy and dignity needs of their patients. We observed staff being respectful at all times during the inspection.

Compassionate care

- During our inspection we spoke to 23 patients and relatives. Most told us they felt staff showed care although some negative feedback was received.
- We observed good interactions between nurses, radiographers, medical staff, healthcare assistants and administration staff and their patients.
- Staff interactions with people were friendly and welcoming. However, we did not observe many staff approaching people with assistance, rather patients had to ask.
- Some of the positive comments from staff and relatives included, "the clinic was really good and caring, I have nothing bad to say to be honest".
- Some of the negative aspects of care highlighted to us was that staff were often rude and that "nurses are sometimes overworked and looked miserable."
- We were told that chaperones were available for all patients and we saw signs displayed in the waiting areas.
- In the 'bed bay' within imaging, we saw patient's privacy was not always supported using the available curtains.

Understanding and involvement of patients and those close to them

- We saw that the outpatient department and diagnostic imaging kept a choice of patient information leaflets but these were not available in other languages.
- All the patients we spoke with felt well informed about their care including any investigations that were planned.
- The patients told us they felt included in decisions that were made about their care and treatment. One patient in the eye clinic told us they felt the nurse and consultant understood their needs. They felt respected and staff gave them the opportunity to ask questions.

Outpatients and diagnostic imaging

- The results of the friends and family survey were displayed within the departments. Performance targets for the directorate were not met to date with 78% of patients saying they would recommend the service against a trust target of 92%.

Emotional support

- Patients told us staff were professional and supported them well.
- There was a chaplaincy service in place which could be accessed if required.
- Staff told us a quiet room would be made available for breaking bad news.
- Psychology support was available for some of the clinics.
- The main waiting area for outpatients was calm and well-ordered although very little provision was made for children.

Are outpatient and diagnostic imaging services responsive?

Requires improvement



We rated responsive as requires improvement because:

- Patients told us it was often very difficult to get through on the appointments telephone helpline to either change an appointment or seek advice.
- The service monitored complaints but there was little evidence of implementing any learning from the complaints.
- Staff were not able to tell us of the support given for patients with a learning disability or dementia.
- Patients and staff told us clinics were often overbooked and ran late but we observed good communication with the patients.
- There were no patient leaflets available in other languages other than English.

However:

- We found that some improvements had been made since the last inspection. The trust was meeting national

waiting times for diagnostic imaging within six weeks and outpatient appointments within 18 weeks for the incomplete pathways. Some ultrasound examinations were at nine weeks wait.

- Cancer waiting times were variable across the targets although waiting times for all urgent referrals were within two weeks.
- Most of the clinic cancellations gave over six weeks' notice. The primary reasons given for clinic cancellations were annual leave, study leave or sickness.
- There was access to interpreters for patients whose first language might not be English and the outpatient department employed three Turkish link workers to meet the needs of the local population.

Service planning and delivery to meet the needs of local people

- Waiting times were displayed on white boards in the waiting areas for patients and on the ground floor reception for diagnostic imaging.
- Signage to outpatients and diagnostic imaging services was clearly displayed at the main reception and in the corridors.
- During our inspection we visited the phlebotomy clinic. This was a walk in clinic meaning patients did not need to make an appointment. We noted there was a 25 minute wait for blood tests at the time we inspected.
- The age suitability of the nuclear medicine equipment was a concern. It had been on the risk register since 2009.
- Voice recognition reporting in diagnostic imaging was in place and used effectively.
- 99% of GP, 94% of accident and emergency and 88% of outpatient plain x-rays were reported in less than 10 days.
- 95% of inpatient images were reported on the same day and 97% of accident and emergency CT tests were reported in under one hour.
- Radiographers had been trained and were competent in some aspects of radiology reporting such as chest, axial and appendicular skeleton.
- Bariatric chairs were not available in outpatients or diagnostic imaging.

Access and flow

Outpatients and diagnostic imaging

- The hospital episode statistics for March 2015 – February 2016 showed that a total of 466,872 outpatient appointments were made at the hospital and other clinic sites.
- Out of the total appointments made at the hospital, 20% had been cancelled by either the hospital or by the patients. The data did not break it down further into the reasons for cancellation.
- The referral to treatment rate for incomplete pathways between July 2015 and June 2016 ranged from 91.4% and 99.4%. The results have been consistently above been the standard of 95% since July 2015.
- The percentage of cancer patients seen by specialist within two weeks of an urgent GP referral was below the 93% standard in quarters 2 and 4 of 2015/16 and quarter 1 2016/17. The standard was met in quarter 2 of 2016/17.
- The percentage of cancer patients waiting less than 62 days from urgent GP referral to first definitive treatment was below the 85% wait standard and England average in quarter 2 of 2015/16 and quarter 1 2016/17. Despite the standard being met in quarter 3 and quarter 4 of 2015/16 the standard was at 73.8% in quarter 2 of this year.
- Weekly access meetings were held to monitor the appointments and clinic availability. Waiting list initiatives had demonstrated effectiveness against waiting times but staff were overstretched.
- Waiting times for diagnostic imaging were monitored and recorded. The percentage of patients receiving their diagnostic test within 6 weeks from referral was at 99% in May 2016.
- Requests for laboratory diagnostic tests were sent electronically from the wards and GP surgeries.
- The staff we spoke with demonstrated limited understanding of the needs of patients with dementia and learning disabilities. We were not assured in our discussions with staff that the patient who may be distressed or confused would be treated appropriately.
- Information about local support groups was displayed in the waiting areas.
- We had mixed feedback from patients about their experience of attending the outpatient services. Overall patients we spoke with were very positive about the diagnostic imaging services and told us they received good treatment and were happy to attend the department. The directorate were not meeting their target set against the friends and family test for achieving an overall positive experience. The results in May 2016 showed an overall positive patient experience of 83% against the target of 90%.
- We observed and were told by staff that there were often long waits for portering services.

Learning from complaints and concerns

- The outpatient's senior staff told us the main reason for complaints in the department was waiting times. On reviewing the directorate report for March 2016, staff attitude was also a main theme for complaints.
- Complaints were handled in line with the trust policy although the response rate within trust timescales was at 73% against a target of 80% from January to March 2016.
- Staff were able to explain the complaints procedure to us and most staff felt they were handled well with local resolution.
- We saw that PALs signs were situated throughout outpatients and imaging which explained how to raise any concerns or complaints. One patient told us how PALs had been very good at helping to support an issue they had within outpatients.

Meeting people's individual needs

- We noted that water dispensers were available throughout the outpatients department and a small café was located near the main outpatient's area.
- Staff told us interpreting services could be booked for patients attending outpatient appointments if the original referral letter stated an interpreter would be required. We saw posters clearly displaying information about accessing translation services. We were told that pharmacy tried to communicate with people in their own language by informal means but there were no patient leaflets available other than in English.

Are outpatient and diagnostic imaging services well-led?

Requires improvement



We rated well led as requires improvement because:

Outpatients and diagnostic imaging

- There were several new senior staff in post over the last few months and although improvements were evident from the previous inspection, most changes were yet to be embedded.
- Many staff, particularly within outpatients, did not feel supported and able to develop and progress within the organisation.
- Staff told us they were able to raise concerns and put forward ideas for improvement of services within diagnostic imaging but they were not always implemented.

However:

- Staff told us the new chief executive was starting to make a positive difference.
- Staff we spoke with were proud of the teamwork and wanted to provide the best service they could for their patients.
- Outpatients had an improvement and transformation project in place with an ongoing action plan.

Vision and strategy for this service

- There was no capital replacement programme in place for the diagnostic imaging equipment. Although, there was a strategy in place for the workforce to meet capacity and demand, this had not been matched to equipment requirements. Staff were not aware of the strategy and some anxiety was raised due to frequent senior manager turnover and appointments.
- Outpatients had an outpatient transformation project looking at waiting times, missing records, workforce and access to the service. Some staff told us the actions had not all met their timescales but that work was progressing.
- All the staff we spoke with were aware of the trusts vision and values.
- All the staff spoke with pride about their services.

Governance, risk management and quality measurement

- Governance arrangements were in place but were not yet embedded. A new managing director for the clinical business unit started the week of the inspection. We were able to review the Clinical Business Unit minutes from July 2016 but senior staff told us they were not happy with the quality of the minutes prior to this.

- We saw the departments had risk registers in place and risks that had been identified in our discussions were reflected on these registers. These included replacing radiology and lack of staffing in outpatients to meet the demand.
- Vacancies for staff were all currently advertised. The reduced staffing impacted on the quality of the service received, for example increased waiting times in outpatients.
- Audit systems were in place to measure the quality and accuracy of work carried out within the departments. This included audit half days for staff to attend.
- Governance processes were in place for radiation safety monitoring. There was a radiation protection committee (RPC) consisting of specialist staff across the diagnostic imaging disciplines that met on a quarterly basis. Individual services reported on a risk and safety issues relating to radiation protection for example the progress of the business case to replace the gamma camera which had been on the risk register for several years. A new Radiation Protection SLA was now in place as of 1st April 2016.

Leadership of service

- The senior team consisted of the clinical director for the clinical business unit, the managing director, outpatients matron, health records manager and the imaging services manager covering both diagnostic and therapeutic radiography.
- We spoke with senior staff managing each of the clinical areas we visited. We had mixed feedback from staff about the confidence they had in their leadership. They felt there had been a long time of uncertainty and change within the leadership structure. Some staff felt overlooked in their role progression and saw external staff appointed with seemingly less experience.
- Staff made comment that the new chief executive was a good appointment for the trust and they felt optimistic for the future.
- The senior managers we met with were aware of the strengths and weaknesses of the services they led. Although, we discussed objectives and vision for the service there was a lack of overall direction and more work needed to be done to lead the services forward.

Outpatients and diagnostic imaging

- We looked at and discussed with senior staff the cancer action plan. We noted there had been progress made against the cancer performance targets. Staff were able to identify where further work was required to improve performance such as in histopathology reporting times.
- Pathology services had been reconfigured and the healthcare scientist staff were managed by an external company.
- Senior staff told us they had engaged with the local commissioning group to look at patient education and patient choice to inform and enhance the patient experience.
- Staff told us the information from the new executive team on the intranet was engaging and contained a good level of information.

Culture within the service

- Staff told us there was good teamwork and people were there to help each other.
- Some staff in both outpatients and diagnostic imaging teams told us there was often a barrier with the senior management teams and they were not listened to.
- The majority of staff described a positive working environment. Many of the staff had worked at the hospital for many years. However, several staff told us they felt demoralised and unable to raise their concerns.

Public and Staff engagement

- The departments actively sought feedback from patients.
- They took part in the friends and family test across the various units.

Innovation, improvement and sustainability

- Advanced practice was evident in the radiology department with reporting radiographers.
- The hospital had started to offer an appointment reminder service where patients were reminded of their outpatient appointment by a free text message.
- There was a reliance on outsourcing radiology reporting in order to support the on call rota and reporting times. We were unable to see a future plan for dealing with the increasing numbers of referrals and reports.
- The regular access meetings had made improvements to patient waiting times.
- A new business case had been submitted to take the lead in diagnostic imaging to gain ISAS accreditation status.
- The trust had actively engaged with the apprenticeship agenda and had employed several apprentices within outpatients and diagnostic imaging.

Outstanding practice and areas for improvement

Outstanding practice

Outpatients and Diagnostic Imaging

- The diagnostic imaging department worked hard to reduce the patient radiation doses and had presented this work at national and international conferences.

Children and Young people services

- Children's services had implemented the S.A.F.E Resource Pack. SAFE is the acronym for Situation Awareness for Everyone(S.A.F.E). The Royal College of Paediatrics and Child Health (RCPCH) has developed this resource safety bundle after a two year trial held in conjunction with 28 hospitals including North Middlesex.

Areas for improvement

Action the hospital MUST take to improve Urgent and Emergency Services

- The trust must ensure learning from incidents is more robust and shared with all staff.
- The trust must ensure that all medicines and instruments associated with a resuscitation are disposed of safely after use.
- The trust must ensure the renewal of advanced paediatric life support (APLS) certificates of those doctors and consultants whose certificates had expired
- The trust must improve mandatory training levels for medical and nursing staff.
- The trust must improve safeguarding adults level 2 training for medical and nursing staff.
- The trust must improve safeguarding children level 2 training for medical and nursing staff.
- The trust must improve hand hygiene levels especially amongst medical staff.
- The trust must ensure medical and nursing staff are fully trained and able to identify and support the needs of patients living with dementia.
- The trust must ensure medical and nursing staff are fully trained and able to identify and support the needs of patients with learning disabilities.
- The trust must improve appraisal rates of nurses.

Surgery

- The trust must ensure all actions in response to the never event are fully implemented.

- The trust must review and identify causes for the higher than the national average mortality rate as suggested by the bowel cancer and the national hip fracture audit data.

Outpatients and Diagnostic Imaging

- The trust must ensure there are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up.
- The trust must ensure there are appropriate processes and monitoring arrangements in place to improve the 32 and 61 day cancer targets in line with national targets.
- The trust must ensure there is improved access for beds to clinical areas in diagnostic imaging.

Maternity and gynaecology

- The trust must carry out an audit of the stillbirth rate for the period January to December 2016 and develop an action plan to address themes.
- The trust must provide one to one care in labour to all women.
- The trust must replace all damaged equipment in EGU and triage.
- The trust must monitor and report in VTE compliance.
- The trust must monitor the temperature of medicines storage.
- The trust must review waiting times in triage and develop an action plan to address themes.
- The trust must ensure mandatory training and multidisciplinary intrapartum care training targets are met.

Outstanding practice and areas for improvement

- The trust must display cleaning schedules or checklists all clinical areas.
- The trust must ensure staff in maternity observe the 'bare below the elbows' policy.
- The trust must ensure patients have a named midwife.

End of Life Care

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

Action the hospital SHOULD take to improve Urgent and Emergency services

- The trust should continue to make improvements to 15 minutes to triage time.
- The trust should maintain consistent achievement of 80% target of 15 minutes to ECG.
- The trust should ensure there is a supply of paediatric emergency medicines in the paediatric high dependency room.
- The trust should develop statement of purpose for escalation when a patient with a mental health illness absconds from the department.
- The trust should record children's weights in paediatric patients' records.
- The trust should rectify IT issues in paediatric ED to ensure all PEWS scores are recorded.
- The trust should develop a chest pain pathway.
- The trust should develop a frailty pathway.
- The trust should ensure there is a sufficient number of wheelchairs available to facilitate timely ambulance handover of patients.
- The trust should improve patient comfort with the availability of snacks for patients 24/7.
- The trust should improve quality of major incident awareness amongst all staff.

Surgery

- The trust should ensure departmental risk register indicates how risks are to be mitigated and who is responsible for implementing actions.
- The trust should ensure staff improve recording of pressure ulcers, raise incidents and safeguarding alerts when appropriate.
- The trust should ensure reporting of actions from mortality and morbidity meetings is formalised and ensure learning and actions are shared across the trust.

Outstanding practice and areas for improvement

- The trust should ensure individual venous thromboembolism risk assessments (VTE) are fully completed for all patients.
- The trust should improve average waiting time for a patient discharge prescription.
- The trust should improve utilisation rate for operating theatres and its efficiency.
- The trust should review if all qualifying patients are screened for dementia.

Critical Care

- The trust should ensure all staff have adequate knowledge of safeguarding policies and processes.
- The trust should ensure nurse to patient ratios are managed in relation to the individual needs of patients, including whether they are bedbound and/or cared for in a side room and in relation to the guidance of the ICS core standards for intensive care.
- The trust should ensure staff have appropriate support and supervision to meet their needs in relation to professional and contractual activity.
- The trust should ensure all staff who care for patients have the appropriate personal skills to demonstrate understanding and kindness.
- The trust should ensure learning from infection prevention and control audits are implemented by all staff.

Outpatients and Diagnostic Imaging

- The trust should ensure its target for compliance with mandatory training is met by staff.
- The trust should ensure there is access to seven day week working for radiology services.
- The trust should ensure staffing is improved in radiology for sonographers.

Children and Young people services

- The trust should ensure that all children and young people up to their 19th birthday wherever they are cared for in the hospital should come under the governance of children's services which will ensure that they have oversight of all children and young people wherever they are treated in the hospital.
- The trust should improve drug refrigerator temperature monitoring and replace faulty fridges with new equipment where required in order to ensure medication is safely stored.

- The trust should gather feedback from children and young people who use their services and use this information to inform and improve service planning.
- The trust should ensure that play provision for children in hospital should be enhanced to meet national standards.

Maternity and gynaecology

- The trust should develop a clear vision and strategy for the maternity and gynaecology service.
- The trust should review the group sessions for the first antenatal appointment.
- The trust should carry out a review of culture within maternity and use tools such as 'walk in my shoes'.

Medical care (including older people's care)

- The trust should ensure that staff report incidents through the online reporting system and there is a formal process for feeding back to staff.
- The trust should ensure Mortality and Morbidity review meetings are used to identify action points or lessons learnt and that these are recorded.
- The trust should ensure patient records are completed consistently and patient records are always kept confidential and stored securely.
- The trust should ensure staff wash their hands between patients and wear appropriate PPE.
- The trust should ensure that staffing levels on the wards reflect the safer staffing acuity tool to determine safe staffing levels.
- The trust should ensure nursing staff know how to use the settings for the pressure relieving mattress.
- The trust should ensure compliance with mandatory training meets the trusts target for infection prevention and control training, health safety and welfare, information governance, safeguarding, safeguarding children and fire safety.
- The trust should ensure that feeder cups and meals are left within easy reach of patients.
- The trust should ensure that staff are trained in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards and that staff seek patients' consent before care or treatment is given.
- The trust should ensure that activities, such as cards, games or puzzles, are provided on the care of the elderly wards.

Outstanding practice and areas for improvement

- The trust should ensure that staff have feedback about complaints or learning from them.

End of Life Care

- The trust should ensure they meet the minimum requirements for consultant staffing as set out within the Royal College of Physicians guidelines.
- The trust should provide a seven day face to face service as set out within NICE guidance for EoLC.
- The trust should carry out mental capacity assessments on all patients deemed to lack capacity prior to completing a DNACPR form in line with trust policy.
- The trust should keep the risk register up to date at all times.
- The trust should ensure patient care is delivered in line with the patients' care plans at all times.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems and processes were not established or operated effectively to ensure the trust was able to assess, monitor and improve the quality and safety of the services provided. The trust did not effectively assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others.

The trust did not assess, monitor and mitigate the risks relating to the health, safety and welfare of their palliative and end of life care patients. The trust did not code their complaints to reflect the concerns raised with end of life care. This meant that it is possible for complaints to be missed by the trust.

This is a breach of regulation 17(2)(a) in which the provider must assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

The trust did not seek to gain feedback from patients or their relatives; therefore they were unable to act on this information. The bereaved relatives' survey had not been sent out since 2013; therefore, the trust could not identify areas of good practice or areas that required improvement.

This is a breach of regulation 17(2)(e) in which the provider must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services.

There was no end of life care strategy at the time of our inspection.

This section is primarily information for the provider

Requirement notices

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